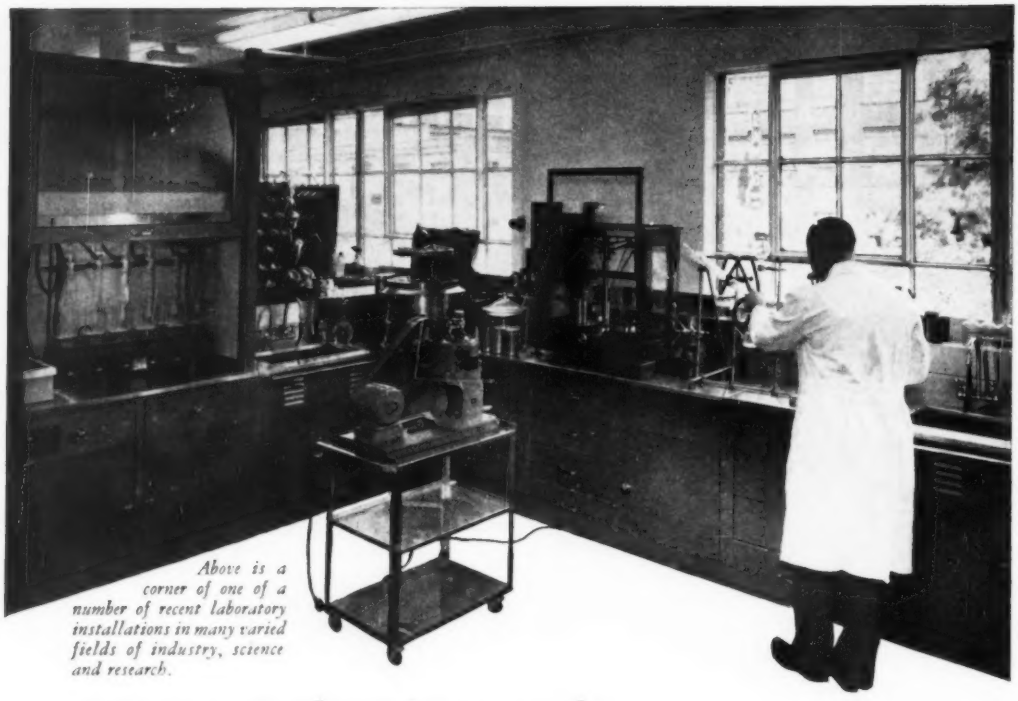
The Modern Hospital

NOVEMBER 1949

Why administrators leave their jobs • Nursing care of rheumatic fever patients • Inventory control • New type of bassinet • Treating alcoholics in the hospital • The new General Rose Memorial Hospital • Postoperative recovery room



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The Modern Hospital

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NOVEMBER 1949

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AMONG THE AUTHORS

Jean Phimister, R.N., is superintendent of the Children's Heart Unit operated by the Victoria Foundation at Morris Plains, N.J., where she has served for the last seven years, developing a nursing program aimed at meeting the special nursing requirements of the child who is hospitalized for rheumatic fever. A graduate of the Western Toronto Hospital School of Nursing, Toronto, Ont., Miss Phimister was assistant night supervisor at the Toronto General Hospital, then entered the field of pediatric nursing and studied child psychology at the University of Pennsylvania. Of the rheumatic fever project described in her article on page 61, Miss Phimister says, "All of us connected with the program have been rewarded by the realization that a happy, profitable experience can be given the child requiring long-term care for active rheumatic fever."

Charlotte C. Dowler, R.N., whose article on the supervisor's responsibility for employe morale appears on page 77, is administrator of the Renton Hospital at Renton, Wash. A graduate nurse whose career reflects her especial interest in personnel problems, Miss Dowler was a member of the staff of the University of Washington School of Nursing for several years, then became director of the nursing school at St. Luke's Hospital, Spokane, until five years ago, when she took over her present position. In addition to her nursing diploma and certificates in supervision and public health nursing, Miss Dowler holds a B.S. degree from the University of Washington and a master's degree in business administration from the University of Chicago.

Sister M. Veronica Murphy, R.N., is administrator of St. Joseph's Hospital, St. John, N.B., a position she has held since 1942 and in which she also served from 1928 to 1934. She has also been administrator of the Holy Family Hospital at Prince Albert, Sask. Before becoming an administrator Sister Veronica served her hospital as superintendent of nurses and as medical record librarian. She is a charter member of the Canadian Society of Record Librarians and has been active in hospital organizations. At the recent American College of Hospital Administrators' convocation at Cleveland, Sister Veronica was advanced to fellowship, having been a member of the college since 1943. She is a member of the Sisters of Charity of the Immaculate Conception, whose Motherhouse is at St. John, N.B. Sister Veronica's article on the administrator's relationship to the x-ray department appears on page 79 of this magazine.

One of the nation's foremost authorities on the subject of alcoholism, **Dr. Robert V. Seliger** is visiting psychiatrist at Johns Hopkins Hospital and chief psychiatrist at the Neuropsychiatric Institute, Baltimore. He is also a member of the attending staffs in psychiatry and neurology at a number of other hospitals in the Baltimore area and instructor at Johns Hopkins University Medical School. Dr. Seliger is executive director of the National Committee on Alcohol Hygiene, an editor of *Alcohol Hygiene*, and advisory editor of the *Journal of Clinical Psychopathology and Psychotherapy*. He is the author of several books and numerous articles for both professional and lay readers. Directed especially to hospital administrators, his article on page 94 deals with alcoholism as a problem of the general hospital.

Roving Reporter

Children on the Air

"Good morning, friends. This is LeRoy Miller broadcasting our regular Breakfast Club from the Children's Heart Hospital of Philadelphia." It was on July 26 at 7 a.m. that LeRoy Miller and the Children's Heart Hospital were on the air.

The routine hospital work was accomplished without difficulty. By 7 a.m. the children were ready to participate in the unusual event. Nonambulatory patients remained on their beds while ambulatory patients drew their chairs as near as possible to the nurses' station where the props of the broadcast were set up. Two engineers had arrived at the hospital at 5 a.m., and when the clock struck 7 everything was in working order.

The children participated in singing their greeting song "Good-day, good-day, dear visitors. We are glad that you have come here today." Some of them were interviewed briefly by Mr. Miller.

It Was a Good Party

Filling station attendants in coveralls, neat rows of cars on a graveled surface —everything was normal at the parking lot at Sixth and Walnut streets, Reading, Pa., on the evening of August 3 and again on August 6.

But no parking lot before had looked, sounded or smelled like that one on the evenings of August 4 and 5. For the big lot accommodated a pony ride and a score of booths and stands. The cries of spielers rang above the clatter of thousands of voices. The tantalizing aromas of deviled clams, hamburgers, hot dogs and waffles assailed the nostrils at every turn.

The two-night block party for the benefit of the building program of Community General Hospital in the heart of Reading, after months of planning, came off. Thursday night was a big night; Friday night was bigger. Many people came both nights; they ate, they played, they laughed, and they spent.

The hospital's 24 auxiliaries each had an event. It was possible for people to do a week's marketing at the fruit and vegetable stands. It was possible for them to get any drink they could name at another stand. A French fry stand, a fish pond, a parcel post window (where attractively wrapped packages were sold)—every device of bazaar and carnival that the groups could arrange brought in money.

Insurance against rain? It wasn't necessary, for the near-by Junior Fire House was to be theirs in case of a change in the weather. Cooperating with the hospital auxiliaries in putting on the block party was the hospital alumnae association.

Food Service Shift Satisfies

Wing by wing, the final step in food service is being transferred from the nursing department to the dietary department at Waterbury Hospital, Waterbury, Conn., to the satisfaction of patients, dietitians, nurses and top management.

The first shift came in North Wing 3; a food supervisor was employed for that section, a selective menu was provided, vacuum coffee servers were purchased, and extra attention was given to the food preferences of patients.

Supt. Charles W. Wynne, in his annual report, says: "Responsibility for food service is in this way properly placed and stricter control is maintained. A sharp decrease in food waste has been noted."

Waterbury Hospital also has initiated a nourishment program for personnel, providing workers with crackers and milk or coffee in the nurses' cafeteria between 9:30 and 10:30 a.m. daily.

Signal for Interns

"Buzz, buzz, testing, testing." That's the signal for interns to report to the necropsy room at the City Hospital of Akron, Akron, Ohio.

But some hours before this signal comes over the inter-com system, some intern or resident has had to convince the family of the need for necropsy proceedings.

Thirteen arguments to use on the next of kin who are reluctant to sign a necropsy permit are given in the "Interns and Residents Manual" put out by this hospital.

This 35-page manual, duly indexed, should prove helpful to other institutions that are revising or instituting such a handbook.

Reader Opinion

Rates

Sirs:

In order to obtain sound hospital financing in the future it is my opinion that it will be necessary to be guided as nearly as possible by the following:

1. That all hospital rates be set with a definite relation to costs.

2. That hospitals have one schedule of rates applicable to all types of patients.

3. That deviation from these rates be made on a careful investigation of the ability to pay and that such deviations be reflected on the books as free service.

4. That institutions rendering free service beyond funds available for such purpose, such as endowment, obtain assistance from community chests and other agencies on the basis of free service rendered.

5. That payments received from Blue Cross, from governmental sources and other organizations, such as the National Foundation for Infantile Paralysis, be on the basis of a cost formula as approved and recommended by the American Hospital Association.

It seems inconsistent with good hospital management that private and semi-private patients should continue to be charged higher rates than others in order to net a profit which in turn might be applied toward free service to indigent patients. It is likewise unexplainable to attempt to tax hospital employes through lower wages than those prevalent in the community for the support of these indigent patients.

I do not believe that this situation is nearly as bad in our area as it appears to be in some other sections of the country. Employes' salaries have been established on a comparable basis with those of employes in other similar institutions. In most hospitals one rate of charges for special services has been established applicable to all patients, the room accommodation only varying in price. Except in cases of luxury accommodations, the over-all billing to patients is made in some relationship to the over-all costs.

I am convinced that it is important that uniform accounting systems must be in operation in our hospitals and that these be under outlined principles set up by the American Hospital Association. I believe it likewise important that hospitals render financial reports on a corresponding basis to show cost comparisons. Comparisons from these reports should be available for study through the American Hospital Association or other organized hospital channels.

Harold P. Dean
Children's Hospital
Los Angeles

Slight Stiffening

Sirs:

My attention has been called to your article on hospital costs in the July issue of The MODERN HOSPITAL.

It was very interesting to read of the various facts and opinions from architects over the country on costs. Our office too has been experiencing pleasant surprises in taking bids in recent months. Although we have not received bids on hospital work in the

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past few months, we have received them on other types of public buildings which indicate that prices are down at least 10 per cent in this area. In one instance bids were about 20 per cent below our estimates.

We believe this has been due to a number of things. The prices of many materials, such as lumber and steel, have been reduced. Profits of the suppliers are being squeezed down as bidding is keener and bidders are plentiful. Skilled labor seems to be more productive and many of the incompetent ones have been weeded out.

However, we have noticed a slight stiffening of prices in the last 30 days, probably because of the unusually large amount of work placed under construction recently.

With reference to the Texas architect's claims, we have found from experience that costs on the type of hospital he describes are at least twice the amount he gives.

Louis F. Southerland

Austin, Tex.

Evolution

Sirs:

I am interested in the considerable concern and controversy regarding socialized medicine; it is a matter remarkably involved with vested interests. The mortality rate of the latter during the last 10 years has been such as to make them very bad risks.

I venture to predict that Canada, as it has been in so many other things, will be first to reconcile successfully the new with the old. In the process, it will retain the best of the past and adopt the most promising of the new.

Certain branches of health and medicine have for many years been successfully socialized in my province of Ontario. I have in mind, particularly, public health departments, mental hospitals, and mental clinics. Here, everyone involved is a civil servant. Yet no one can examine their record, on a comparative basis or otherwise, and not be impressed with their achievements.

Tuberculosis is another outstanding branch of medicine which has been socialized, not by the state, but by the people themselves. Most encouragingly, the government has observed the phenomenal success of this work with understanding interest. It has fostered and encouraged the voluntary features which inherently have a "spark" and momentum that are absent from private or governmental practice. At the same time, the government of Ontario has attempted to obviate the weaknesses of the voluntary system without encroaching on its personality.

Thus, in Ontario, we have 13 large tuberculosis hospitals, each incorporated as a nonprofit organization, each governed and directed by voluntary boards that act without profit or gain. Each sanatorium hires on a salary basis its surgeons, clinicians, technicians, nurses and others. It independently decides rates of pay, working conditions, and so on, just as any other independent employer would.

The government, for its part, facilitates the work of the tuberculosis organizations by "helpful" legislation (usually sponsored by the voluntary organizations themselves) and, more important, by purchasing their service on a "fee-for-service basis." Thus a sanatorium in Ontario *bills* the government for routine ward care, surgery, laboratory, dentistry and overhead.

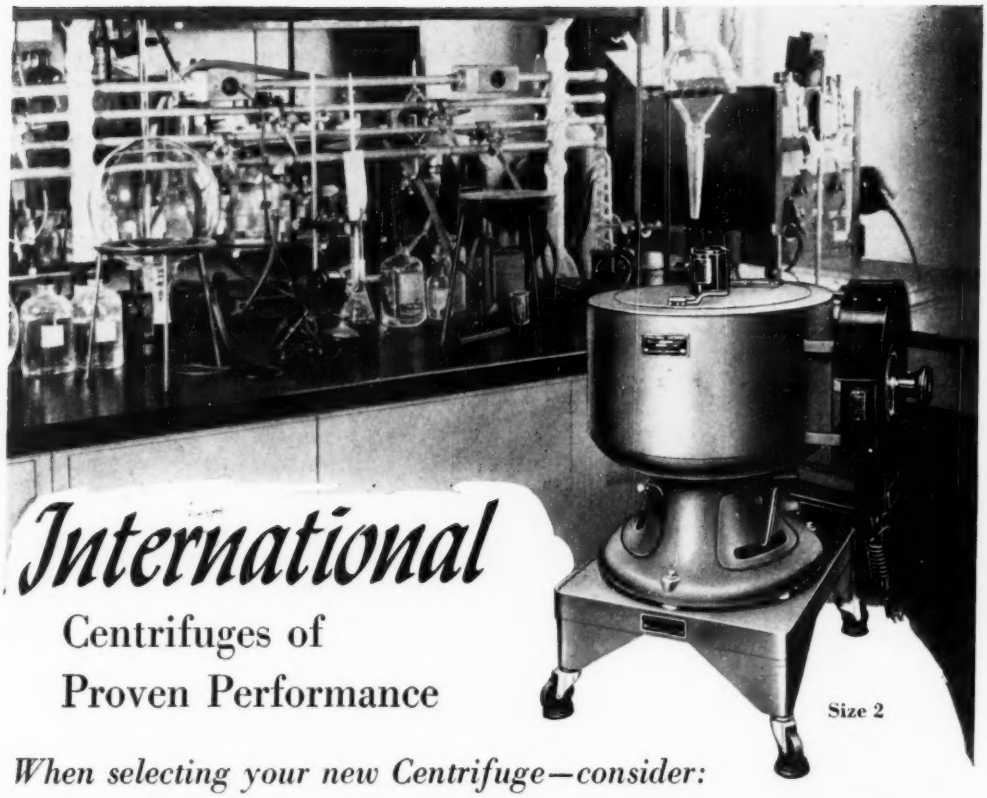
The price paid is not fixed by the government or by the individual sanatorium. It is determined by the collective experience in all sanatoriums for each of these services. Every sanatorium has a uniform cost system. Each surgical procedure, for example, carries a predetermined weight calculated on a system of equalization. The total cost of surgery is determined by the cost systems, and it is a simple calculation to discover the aggregate average cost of one unit of surgery. This becomes the price paid. Similarly with laboratory, dentistry, and other services. Payment received, therefore, may be more or less than actual cost, but is indisputably a fair price. Thus a sanatorium is paid in accordance with its performance. If surgery, say, increases, revenue has a corresponding increase. If economic operation is present, the payment is generous; if inefficiency exists, the loss suffered invites investigation by the trustees.

The secret of the success of this fine experiment is "adequate information." Here again the government serves well. Complete medical and financial statistics for each institution are published each year under one cover, and are sent to all institutions.

Of course, I should add, that as with our public ownership of hydro-electric systems and railways, family allowances, and old-age pensions, it has been more a matter of quiet evolution than of overnight change.

John A. Gunn

Toronto, Ont.



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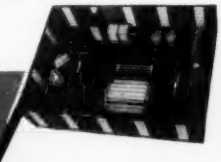

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"Get paid for treatment of indigents?"

"Why—that's almost *controlling the future!"*

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There *is* a "cure"—a "prescription" for every one of those problems—practical, effective and "easy to take" . . . Briefly, here it is:

1. Make friends of patients.
2. Show the interest of the hospital in the patient's family.
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4. See that the people of the community you serve *know all about the services you render—and the problems you have.*

That's the cure . . . the prescription. How to compound it? It's much easier than you think . . . Here's the formula:

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1 part

Hollister Planned Goodwill Program—*(this authoritative, practical working guide for the busy administrator, tells "how to do it"*—and furnishes the material to do it with).

1 part

Hollister Certific-ettes *(used by patients as a clever, novel birth announcement, these miniature reproductions of the Inscribed Birth Certificate actually earn a handsome profit—make it easy for parents to talk about your hospital).*

2 parts

Hollister Babies' Alumni Program *(ideal profit maker for hospital auxiliaries—this Goodwill Builder makes friends of patients—and their children—holds their interest through the years).*

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With that goodwill, the success of your plans for the future will be certain.

Users of Hollister Goodwill Builders will receive this Planned Goodwill Program on request—without charge.

If you would like detailed information about these Goodwill Builders for *your* hospital, write us *today.* Detailed information will be sent you immediately.

Hollister Heirloom Quality

Franklin C. Hollister Company

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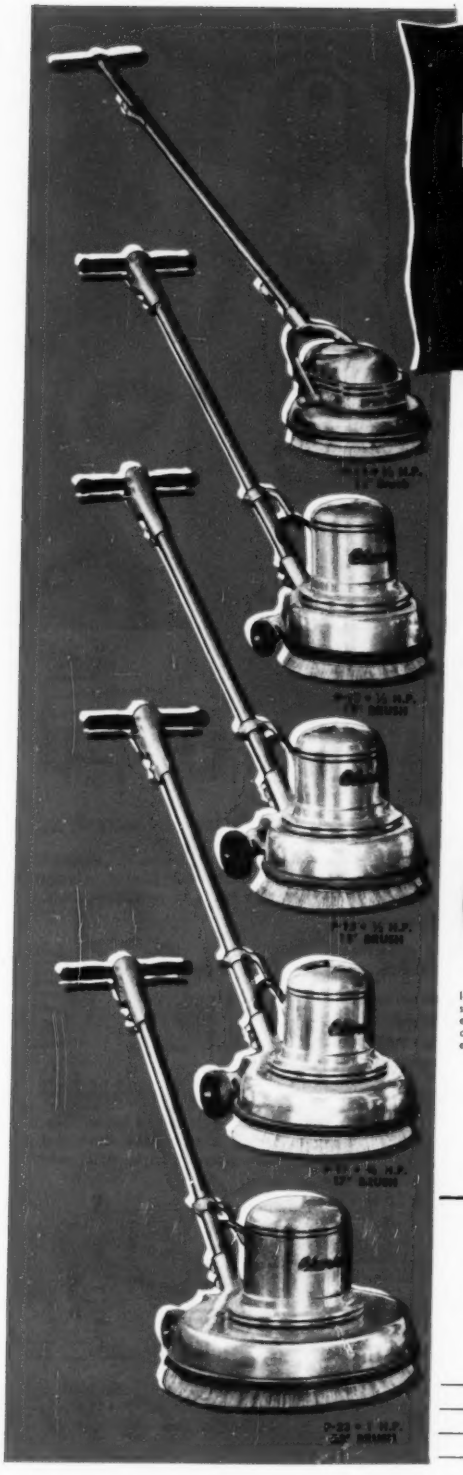
INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—26th Edition



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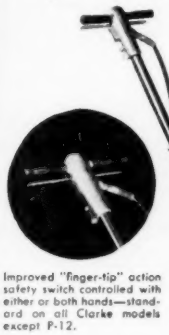

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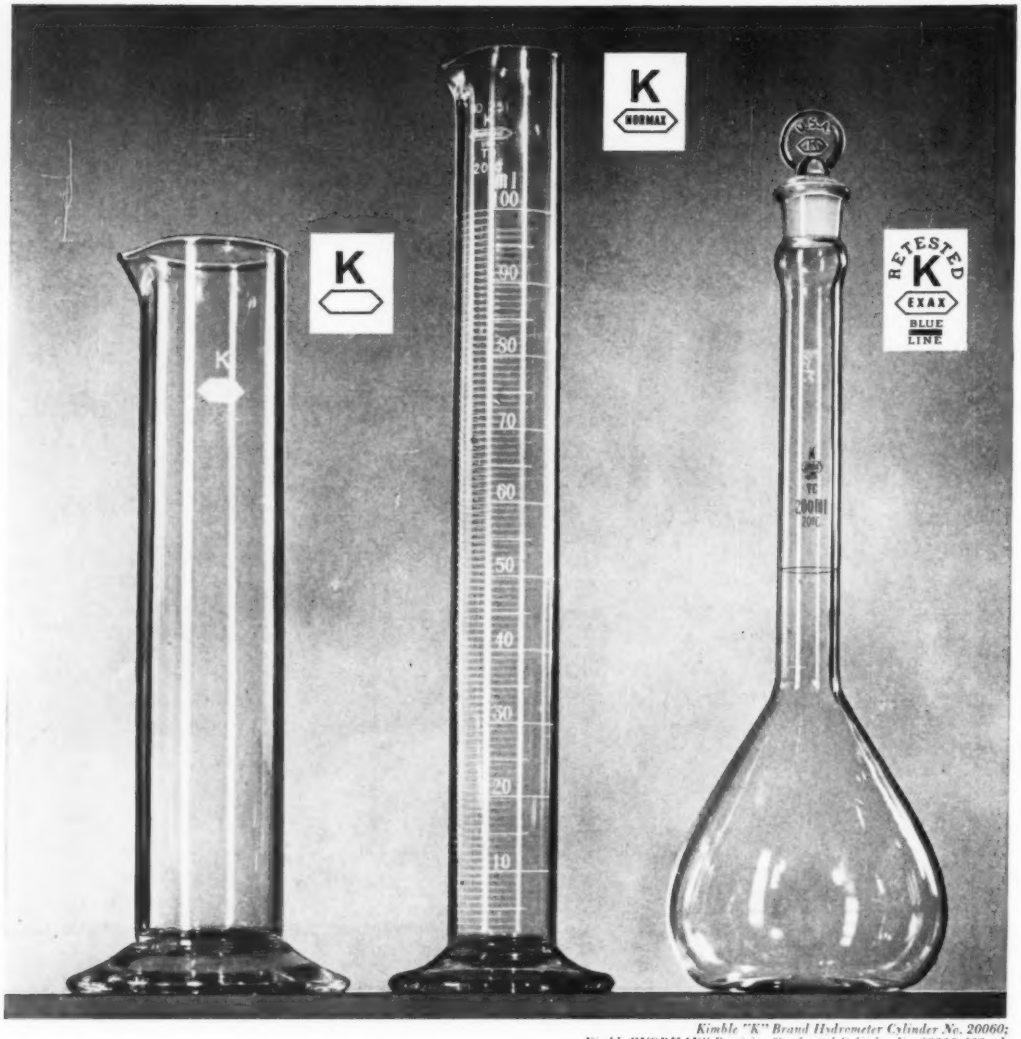
No turning needed .....

No needless bulk! No more heavy lifting! You need never turn a Restfoam Mattress — *at any time!*



Kimble "K" Brand Hydrometer Cylinder No. 20060; Kimble "NORMAX" Precision Graduated Cylinder No. 20026, 100 ml; Blue Line "EXAX" Retested Flask No. 28015, 200 ml.

LOOK FOR THE KIMBLE "K"
the visible guarantee of invisible quality

• Kimble "K" brand ungraduated glassware has been first choice among laboratory technicians for many years. It is accurately made from mold-blown blanks and machine-drawn tubing . . . retempered for maximum durability.

Kimble "NORMAX" is Science's No. 1 PRECISION graduated glassware . . . calibrated, retested and certified to meet requirements of the National Bureau of Standards. "NORMAX" is the symbol of utmost accuracy.

Kimble Blue Line "EXAX" Retested is the most widely used graduated ware. Its accuracy is assured by expert craftsmanship and *individual retesting*. Tolerances are sufficiently small for most laboratory procedures.

SPECIFY KIMBLE FOR ASSURANCE OF QUALITY

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

For Advantages Your Surgeons Enjoy

Specify ROLLPRUF

Pioneer Surgical Gloves

Thousands of hospitals all over the country rely on Rollprufs — because Rollprufs give surgeons better, more comfortable hand protection — last longer, and cost less in the long run.

Look at these Surgeon Pleasing Features!

Flat banded cuffs — an exclusive Pioneer development that stops wrists from rolling down during surgery — reduces tearing, too.

Comfort-fitting — all Rollprufs, both latex and neoprene are more comfortable, less tiring over periods of long wear.

Durable — sheer, to give added sensitivity to your surgeons fingers, yet tough, Pioneer-processed to stand extra sterilizing, giving you longer glove life for your money.

Pioneer Rollprufs — are made of finest natural latex and of DuPont neoprene. Neoprene Rollprufs are made in the new hospital green color for easy sorting, are free of the dermatitis-inducing allergen sometimes found in natural rubber.

Specify Rollprufs on your next order — insist on them from your supplier — or write us. *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*

See our complete Surgical Glove Catalog in Hospital Purchasing File

Pioneer Obstetricals
Made of finest quality latex, elbow length, sheer but tough. Either hand style so any two make a pair — saves pairing and odd gloves.

Pioneer Quixams

Either hand short wrist examination glove, now made of finest quality latex or neoprene. Any two are a pair—less cost.

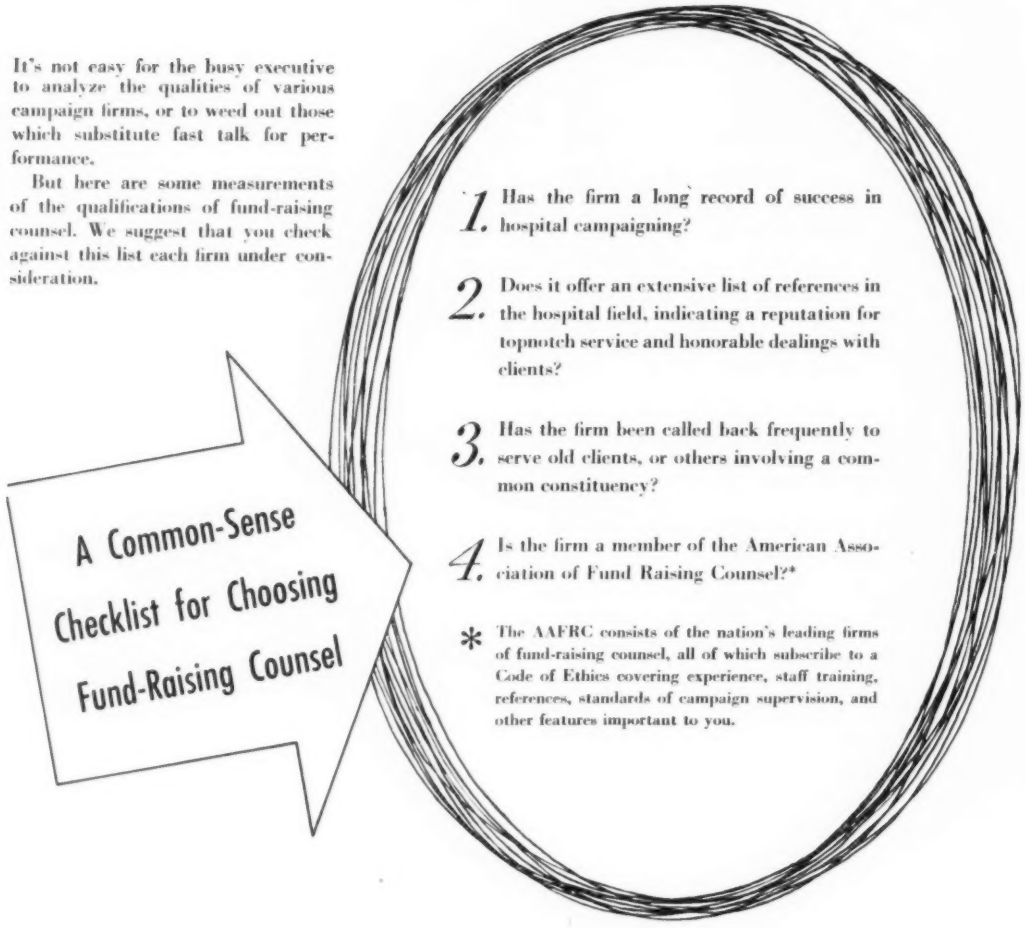
PIONEER Surgical Gloves

★ The Result of Over 30 Years of Quality Glove Making ★

How to Select Fund-Raising Counsel for Your Hospital

It's not easy for the busy executive to analyze the qualities of various campaign firms, or to weed out those which substitute fast talk for performance.

But here are some measurements of the qualifications of fund-raising counsel. We suggest that you check against this list each firm under consideration.



1. Has the firm a long record of success in hospital campaigning?

2. Does it offer an extensive list of references in the hospital field, indicating a reputation for topnotch service and honorable dealings with clients?

3. Has the firm been called back frequently to serve old clients, or others involving a common constituency?

4. Is the firm a member of the American Association of Fund Raising Counsel?*

* The AAFRC consists of the nation's leading firms of fund-raising counsel, all of which subscribe to a Code of Ethics covering experience, staff training, references, standards of campaign supervision, and other features important to you.

You'll discover that Ketchum, Inc. can answer YES to all of these questions.

We will be glad to answer without obligation your questions regarding the direction of hospital fund-raising campaigns.

Ketchum, Inc.

CAMPAIGN DIRECTION

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA.
500 FIFTH AVENUE, NEW YORK 18, N. Y.

CARLTON G. KETCHUM, *President* — NORMAN MACLEOD, *Executive Vice President* — McCLEAN WORK, *Vice President*

Member American Association of Fund Raising Counsel

1919 *Our 30th Year* 1949

NOW... *NEW FREEDOM FOR THE RESPIRATOR PATIENT*

Easy to Apply and Use
Greater Accessibility to Patient
Compact and Really Portable

Here is a respirator that you can use practically *anywhere*. It operates on A.C. power or by rechargeable auxiliary battery. Its compact design requires minimum storage space. Its light, single-front plastic shell can be fitted in 30 seconds and is comfortable to wear. Psychologically, it's a blessing to the patient. It provides far greater accessibility to the patient for treatment or medication. Physical therapy may be included in early stages of poliomyelitis, increasing chances for recovery and reducing the convalescent period.

Six shell sizes accommodate patients of virtually any weight—infants to 275 pound adults. Dual power unit will care for two patients, *at different pressures.* Battery is rechargeable, will cut in automatically if power fails. Manual operation is also possible.

A Typical product from AMERICAN

The MONAGHAN RESPIRATOR is typical of the many products distributed by AMERICAN. It was thoroughly tested* and proved before it was added to the AMERICAN line. It is further evidence of AMERICAN's leadership in discovering or procuring . . . conceiving or developing the better equipment, better products, that make our hospitals the finest in the world. You'll find the new AMERICAN catalog a sound guide in meeting most of your hospital needs.

**Accepted by Council on Physical Medicine of the American Medical Association*

PLAN WITH AMERICAN
. . . the first name in hospital supplies

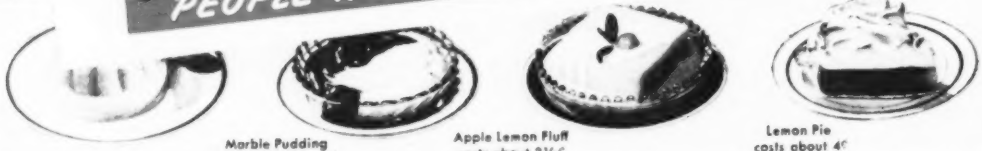
AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES • EVANSTON, ILLINOIS

does TALK work for you?

Awfully boring lying in a hospital bed all day! That's why patients look forward to mealtime as a welcome break in their dreary routines. And when you give them wide variety in their meals—they'll just naturally tell friends and doctors about your good food!

One excellent way to be *sure* of variety is to feature General Foods full line of Institution Products. For General Foods gives you a wide selection of such famous desserts as Jell-O, Jell-O Puddings, Jell-O Lemon Pie Filling and Minute Tapioca; Post's *complete* line of cereals; and a *complete* line of hot beverages including the special institution blend of Maxwell House Coffee—America's largest selling brand of coffee.

PEOPLE WHO TALK ABOUT GOOD FOOD . . .



Marble Pudding costs about 3 to 4¢

Apple Lemon Fluff costs about 2½¢

Lemon Pie costs about 4¢

Here's one Good Way to Help

CUT YOUR FOOD COSTS

below **40%*** *and still be the talk of the town*

**Food authorities say food costs should represent less than 40% of your total operating cost.*

Desserts can account for as much as ⅕ of all your food costs. You can save up to 50% of these costs by serving mouth-watering Jell-O, Jell-O Puddings and Minute Tapioca. These tempting desserts cost only 1½¢ to 4¢ per serving as compared with 7¢ to 9¢ for many other desserts.

You'll find, too, that General Foods desserts are outstanding favorites with patients and hospital employees. Six million American families serve this type of dessert daily. So you can please everyone by serving delicious, wholesome General Foods desserts a different way every day. These low-cost desserts will help you add sparkle and variety to your meal trays.

Standardized quantity recipes for hundreds of low-cost desserts are available. Write today for yours: Institution Food Service, General Foods Corporation, 250 Park Avenue, New York 17, N. Y.

Chocolate Dream Cream, costs about 4¢

Strawberry Tapioca Cream costs about 4¢

HOW TO CHRISTMAS SHOP WITHOUT SPENDING MONEY

Use prize coupons packed with most General Foods Institution Products for valuable gifts. Send for your free prize catalog: General Foods Premium Department, Battle Creek, Michigan.

Carimoca Tapioca costs about 3½¢

TALK ABOUT GENERAL FOODS!

Butterscotch Surprise costs about 4¢

Fruit Cube Sponge costs about 3½¢

Cream and Jell-O Cup costs about 3 to 4¢

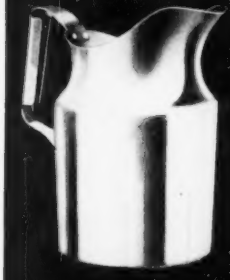
Chocolate Pie costs about 4¢

these aluminum pitchers

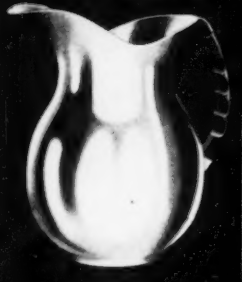
STAY NEW-LOOKING

(Just the thing for careless Kate)

In spite of kitchen bangings and occasional falls, Wear-Ever Aluminum Pitchers keep their good looks. That's because their sturdy construction is combined with an extra tough aluminum alloy that makes them highly dent resistant. Also, they are light to handle and won't rust. A smart buy considering the way they cut your replacement costs and make friends at the table. See your supply house representative or mail the coupon to The Aluminum Cooking Utensil Company, 711 Wear-Ever Building, New Kensington, Pa.



WITH COOL HANDLES
(Style A)
3½ and 4 qt. sizes
Natural or Alumilite Finish



BAKELITE HANDLES WITH FINGER SLOTS
(Style B)
1½, 2½ and 3¼ qt. sizes
Natural or Alumilite Finish

WELDED ALUMINUM HANDLES
(Style C)
1½, 2¾, 3¼ qt. sizes. Two larger sizes have guard to retain ice when pouring.
Natural or Alumilite Finish

WITH COVER
(Style D)
1 and 2 qt. sizes. All aluminum including knob on cover. Covers extra. Alumilite Finish Only

NOW . . . MADE OF EXTRA HARD ALLOY

WEAR-EVER

Aluminum

. . . the metal that is friendly to foods

WEAR-EVER ALUMINUM TRADE MARK REG. U.S. PAT. OFF.

The Aluminum Cooking Utensil Co.,
711 Wear-Ever Building,
New Kensington, Pa.

Please quote me on_____pitchers
style A ☐; B ☐; C ☐; D ☐; capacity_____qts.,
finish _____.

NAME_____

WITH_____

ADDRESS_____

CITY_____STATE_____

The First "Push-Button" Sterilizer

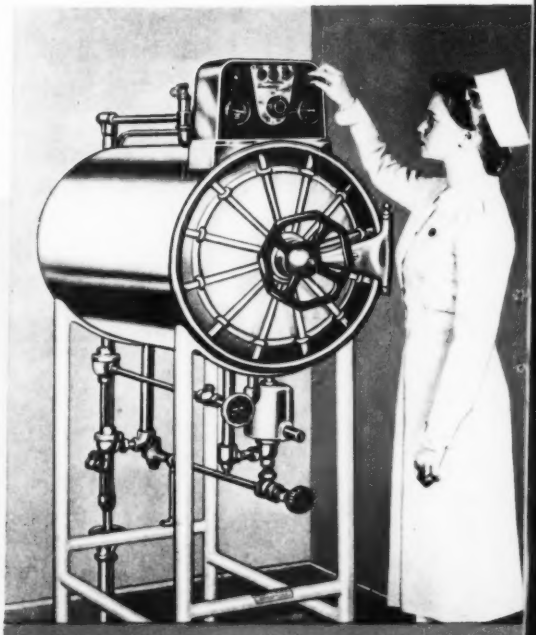
. . . relieves the human element with electromatic control of accurate, split-second precision.

AMERICAN STERILIZER COMPANY • Erie, Pennsylvania

DESIGNERS AND MANUFACTURERS OF SURGICAL STERILIZERS, TABLES AND LIGHTS

Simplifies standardization of all sterilizing procedures . . .

automatically, and with time-saving economies



Additional Highlights

SAVES VALUABLE TIME—eliminates need to continuously watch and manually control each step of the sterilizing cycle.

ACCOMMODATES ALL TYPES OF LOADS—fluids, rubber goods, instruments, utensils and wrapped supplies which require drying out in the chamber before removal.

PERMITS GREATER LOAD OUTPUT—as automatic buzzer alarm announces completion of a cycle and enables operator to introduce a new load with minimum time loss.

STANDARDIZES ALL STERILIZING PROCEDURES—permits accurate repetition of sterilizing processes for each type of load.

OPERATES BY MANUAL CONTROL

in event of electrical current failure

Adaptable to all

"American"

Surgical Supply Sterlizers

(cylindrical type)

and

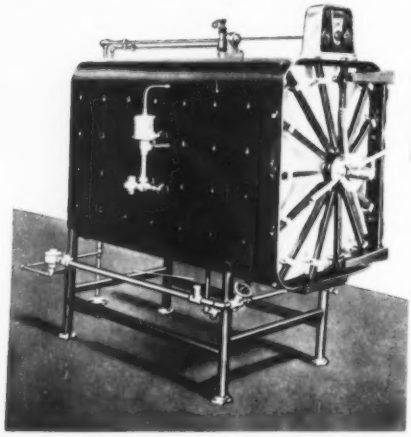
"American"

Bulk Sterlizers

(rectangular type)

that are now equipped with Top Operating Valve

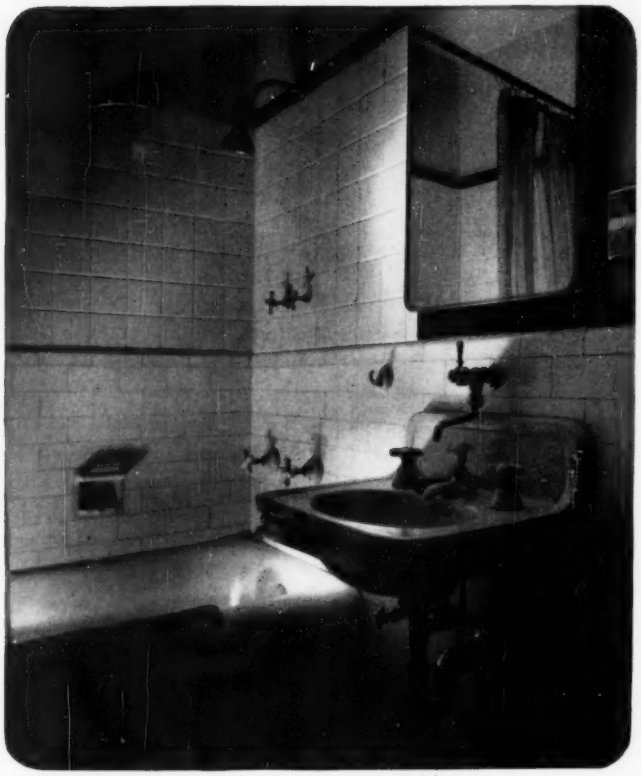
Cycle-Modernize your present "American" Sterilizers.



Adaptable for both Open-Mounted and Recessed Installations

Printed in U. S. A.

Remodeling with MOSAIC Tile
WILL COST YOU LESS, TOO!



Mosaic Tile costs less to install—with Mosaic's fast, low cost and widely proved Lockart Method.

Mr. A. B. McConnell, Vice President of Hollywood-Roosevelt Hotel at Hollywood, California, says—

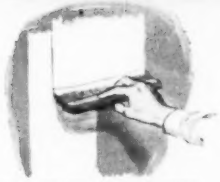
Hollywood Roosevelt Hotel
7000 Hollywood Boulevard
Hollywood 28, California

BILL HOWELS

"We experienced no loss of room revenue while this remodeling was accomplished. It was not necessary to tear out plaster or make any structural changes."

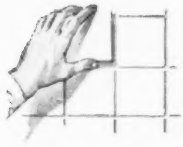
Very truly yours,
A. B. McConnell
A. B. Mc Connell
Vice President

If this hotel can do it—so can you, as thousands of owners in all types of buildings have learned.



QUICK, EASY PRIMING

THEN . . . LOCKART EXPANSET FOR PERFECT ADHESION



FAST APPLICATION . . . FAST SETTING

MOSAIC

LOCKART METHOD

• To find out how much less it will cost you to have genuine Mosaic Tile in your building, *new or remodeling*, ask your tile contractor or use this handy coupon for full information.

THE MOSAIC TILE COMPANY • DEPT. 8-10, ZANESVILLE, OHIO

Please give me full information about your Lockart Method of setting tile at low cost.

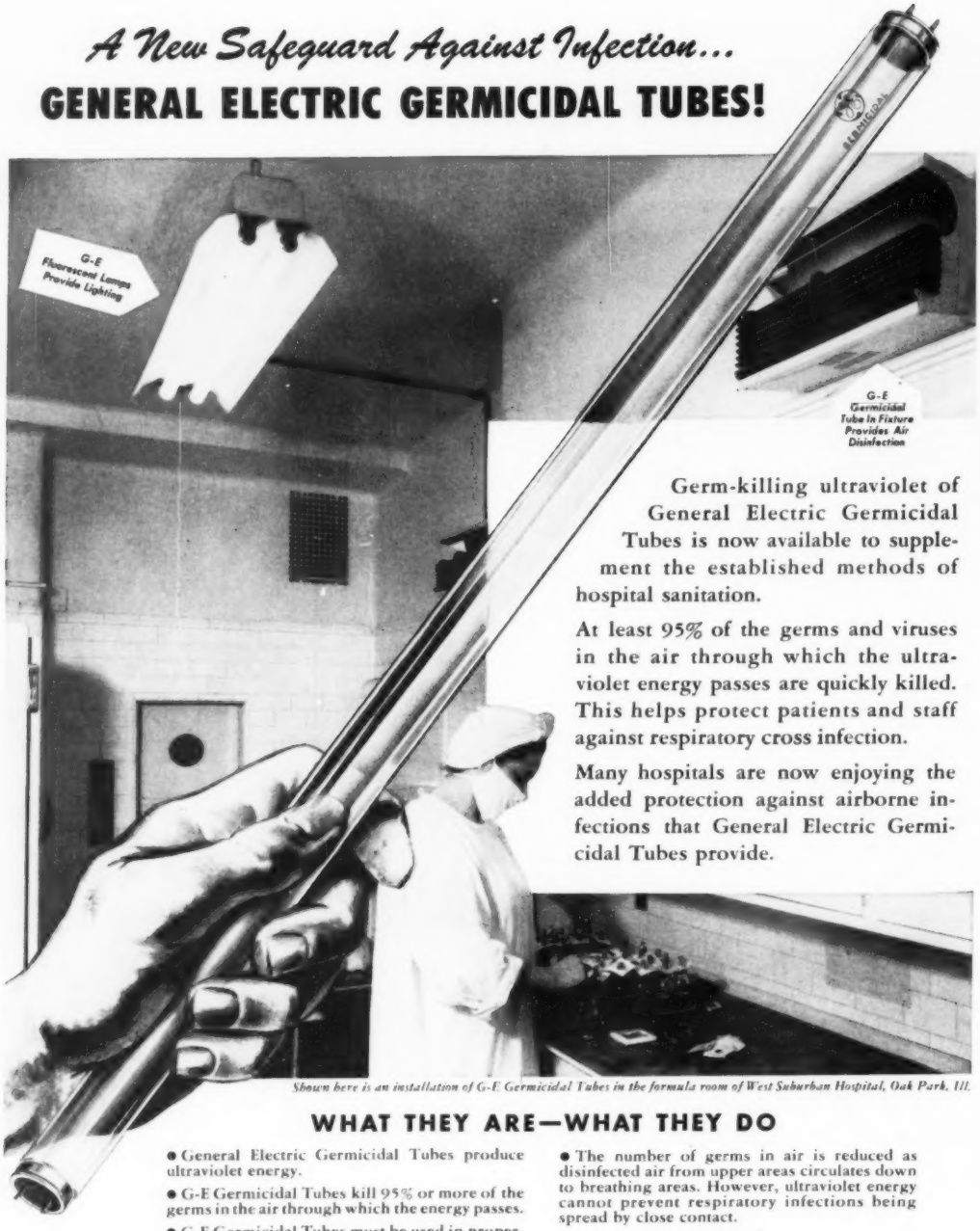
NAME _____

ADDRESS _____

CITY _____ STATE _____

A New Safeguard Against Infection...

GENERAL ELECTRIC GERMICIDAL TUBES!



Germ-killing ultraviolet of General Electric Germicidal Tubes is now available to supplement the established methods of hospital sanitation.

At least 95% of the germs and viruses in the air through which the ultraviolet energy passes are quickly killed. This helps protect patients and staff against respiratory cross infection.

Many hospitals are now enjoying the added protection against airborne infections that General Electric Germicidal Tubes provide.

Shown here is an installation of G-E Germicidal Tubes in the formula room of West Suburban Hospital, Oak Park, Ill.

WHAT THEY ARE—WHAT THEY DO

- General Electric Germicidal Tubes produce ultraviolet energy.
- G-E Germicidal Tubes kill 95% or more of the germs in the air through which the energy passes.
- G-E Germicidal Tubes must be used in properly designed and correctly installed fixtures to prevent irritation of human eyes and skin. Usually the tubes are placed to disinfect the area in a room above eye level.
- The number of germs in air is reduced as disinfected air from upper areas circulates down to breathing areas. However, ultraviolet energy cannot prevent respiratory infections being spread by close contact.

* * *

The Council on Physical Medicine of the American Medical Association has accepted General Electric Germicidal Tubes for air disinfection in hospitals.

Write for free booklet "Air Sanitation" and a folder on hospital use of G-E Germicidal Tubes. Address General Electric, Dept. 166-MH10, Nela Park, Cleveland 12, Ohio.

GENERAL ELECTRIC

Modern 4-Machine Laundry at Rosary Hill Convalescent Home quickly and beautifully washes all laundered work, removes excess water, attractively irons flat pieces, fluff dries items not ironed.

American MODERNIZED the Laundry Department

at 22-Bed Rosary Hill Convalescent Home, Justice, Illinois

Problem: Household type laundry equipment at Rosary Hill Convalescent Home, Justice, Ill., was slow, undependable, costly to operate. Excessive labor was required to launder linens, wearing apparel and uniforms for patients and staff.

Solution: Our Laundry Advisor was called in. He carefully surveyed laundering requirements and submitted his recommendations. The Home then installed 4-Machine Laundry consisting of 32x30" CHAMPION CASCADE Washer, MONEX Extractor, Gas Heated AIRCRAFT Drying Tumbler and Flatwork Ironer.

Results: Rosary Hill reports faster laundering has enabled them to reduce linen inventory. Valuable space has been saved, quality of work is much better. Four operators, who previously put in 30 to 36 hours weekly, can now do all laundering in 8 hours a week.

Why not talk over your laundering problem with our Laundry Advisor. There's no obligation. WRITE TODAY.

Remember . . .

Every Department of the Hospital Depends on the Laundry.

THE AMERICAN LAUNDRY MACHINERY COMPANY

CINCINNATI 12, OHIO

How much TOO MUCH does floor cleaning cost you?

Look at your annual floor upkeep bills and you're in for some surprises.

Notice: labor takes 90% or more of your floor dollars. If you use floor cleaners that work slowly . . . if your wax "walks off" and gets slippery after moderate traffic and needs frequent stripping and reapplication . . . extra labor boosts your costs 'way out of line!

How much? Up to 69% . . . according to leading buildings who save that much with the Legge System. One hospital eliminated five rewaxings a year and chopped $19,000 from a $60,000-a-year floor-care bill. Another building cut out weekly waxings and bi-monthly strippings to slash costs by 69%.

Hocus-pocus? No. Legge floor polishes are designed to produce a clean, glossy finish that is *safe* . . . and have reduced falls on slippery floors up to 95%. They've got to be good. They're exceptionally wear-resistant and easy to use.

What's more, Legge Safety Engineers supervise their use; teach crews efficiency; replace haphazard maintenance with a *plan* that assures continuously safe, clean, bright-looking floors—and whittles dollars off housekeeping budgets. Their services are free with Legge products.

The Legge System can save *you* money. To get the facts, clip the coupon to your letterhead and mail. Walter G. Legge Company, Inc., New York 17, N. Y. Branch offices in principal cities.

Walter G. Legge Co. Inc.
101 Park Ave., New York 17, N.Y.
Without obligation, please send me complete details on the Legge System.

Signed_____

Title_____

Types of flooring_____

Area:_____ Sq. ft. HB-1

LEGGE SYSTEM
of Safety Floor Maintenance

To Prevent Operating Room Explosions: Start with the floor

Of all causes of operating room explosions, sparks from static electricity discharges are the most insidious. Large static charges build up quickly and unseen from simple acts like walking across a floor, handling a wool blanket. Then, if they leap across space as a spark, they can ignite anesthetic vapors.

The accepted hospital preventative is to make the operating room floor *conductive* of static electricity to drain off static charges before they accumulate.

POINTS TO CONSIDER IN CONDUCTIVE FLOORS

Legge Safety Engineers make the following points in relation to conductive floors in hospitals:

1. To be fully conductive, the entire area of the floor must be a low-resistance conductor. And the whole area must be connected to a ground, through which the currents can pass off harmlessly.

2. Existing floors of ordinary composition can be made conductive with Conducote. This plastic coating, manufactured by the Walter G. Legge Co., is painted over a grounded wire grid. It gives a seamless, easy-to-clean floor surface that is conductive.

3. Everything in the operating suite should be effectively grounded. Tables and equipment must make floor contact with metal or another conductor. If they don't, chains or similar devices can be used. Individuals must also be in effective contact with the floor. Rubber heels destroy conductivity—as does the floor wax that often accumulates on shoe soles. Wearing a No-Stat grounding device, another Legge product, overcomes these difficulties.

4. Floor maintenance must not coat the floor with insulating materials—like soap or wax. Legge Safety maintenance products are usually recommended because, when used as directed, they do not destroy the conductivity of a conductive floor.

HOW EFFECTIVE IS YOUR CONDUCTIVE FLOOR?

Readings of your conductive floor can be taken to determine how capably it absorbs static charges. Legge Safety Engineers will gladly make them free of charge—and without obligation—for any hospital in doubt. Just write "Test my Conductive Floors" on the line for Type of Floor in the coupon to the left of this page; clip it to your letterhead and mail to Walter G. Legge Co., Inc.

80 WINDOWS ...OR 8000

FIBERGLAS* *Marquisettes*

cut your curtain maintenance in half!

Columbia-Presbyterian Medical Center found by test and analysis that Fiberglas marquisettes cut their curtain maintenance 56%. On 80 or 8000 windows, this represents an important saving!

Any hotel, hospital or similar institution—large or small—can cut their costs with Fiberglas marquisettes because they

- **Stay clean longer—less washing!**
- **Need no ironing—no stretching—no altering!**
- **Can't shrink—no sorting and pairing!**

Just wash and hang them! Their translucent beauty adds charm to every room. They're sun-fast, sag-proof, rot-proof, silverfish-proof, mildew-proof, stain-resistant and water-repellent, too. *And they cannot burn!* Available through leading distributors, or write Owens-Corning Fiberglas Corporation, Decorative Textile Division, Dept. 989, 16 East 56th Street, New York 22, N. Y.

Fiberglas marquisettes in a parlor at the Columbia-Presbyterian Medical Center. The fire-resistant draperies of Fiberglas yarn and wool are by Knoll Associates. Descriptive dropery booklet available on request.

OWENS-CORNING FIBERGLAS *Yarns*

*OWENS-CORNING FIBERGLAS CORPORATION PRODUCES FIBERGLAS YARNS AND CONVERTS MARQUISETTES MADE OF FIBER GLAS YARNS—IT DOES NOT MAKE OR MANUFACTURE FINISHED CURTAINS.

*FIBERGLAS AND CONSTRUCTED ARE TRADE MARKS OF OWENS-CORNING FIBERGLAS CORPORATION

"We highly commend DURACLAY*"

St. Anthony Hospital, Milwaukee

"The Crane wash-up sinks and other plumbing equipment furnished for our operating rooms have proved entirely satisfactory; we like them very much. They are convenient, attractive, easy to clean, and large enough for all our needs. We have received many favorable comments. We highly recommend Duraclay in the surgical service departments."
Sister M. Bernadette, Administrator, ST. ANTHONY HOSPITAL

- Duraclay is completely immune to thermal shock.
- Duraclay resists abrasion.
- Duraclay is stainproof.
- Duraclay doesn't craze despite years of constant usage.

You can get Duraclay in a full line of hospital sinks and baths. Also from Crane: conventional plumbing fixtures for nurses' quarters, patients' rooms, etc. —plus all the specialized equipment that hospital service demands. Check your plans with your Crane Branch, Crane Wholesaler, or Local Plumbing Contractor.

Write for free copy of Crane Hospital Catalog

Duraclay wash-up sinks in Surgery, St. Anthony Hospital

*duraclay *exceeds the rigid tests for earthenware (vitreous glazed) established in Simplified Practice Recommendations R-106-41 of The National Bureau of Standards*

CRANE

CRANE CO., GENERAL OFFICES: 836 S. MICHIGAN AVE., CHICAGO 5
PLUMBING AND HEATING VALVES • FITTINGS • PIPE

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

Martex ® Fairfax ®

towels • toweling • bathmats

AND NOW

NEW sheets and pillowcases

type 128—type 140

Ability to withstand brutal wear and to give long, satisfactory life in hard service is true of both MARTEX and FAIRFAX cotton towels and toweling. These sturdy quality towels are woven especially to assure economy in use.

The same ability to withstand hard wear is also true of the new, lovely but durable FAIRFAX sheets and pillow cases.

"If only everything we bought lasted as long as MARTEX."

Hospital management has come to respect the long life in use of MARTEX name-woven terry towels.

For MARTEX towels are deliberately built to withstand heavy hospital wear. The sturdy construction of MARTEX terry towels starts in the plied ground warp threads that insure added strength and resistance to wear.

For economy's sake, specify MARTEX on your towel purchase orders.

products of **WEST POINT MANUFACTURING COMPANY**
WELLINGTON SEARS COMPANY, *selling agents*
65 Worth Street, New York 13, New York

BOSTON CHICAGO DETROIT ATLANTA PHILADELPHIA SAN FRANCISCO LOS ANGELES NEW ORLEANS ST. LOUIS

Designed for the Hospital!

. . . with emphasis on

ECONOMY, CLEANLINESS, DURABILITY

THE WALLACE SILVERSMITHS have made an exhaustive study of the *special* holloware requirements of hospitals for patient food service. Today, as a result of this study, a holloware service has been developed that takes into consideration all of the "musts" attendant on this important phase of hospital management. They are:

ECONOMY. Wallace holloware, amortized over a few years, not only pays for itself, but will return a *dividend* in reduced cost of inventory replacements.

SAFETY. In designing this holloware, every attempt was made to eliminate inaccessible, germ-breeding corners. You will find the coffee pot has straight-up-and-down sides, easily and quickly cleaned. Even its spout was designed with hygiene in mind!

QUALITY. Wallace holloware is 18% nickel silver base, silver soldered and heavily silver plated. It is *durable!*

PRESTIGE. Patient goodwill and prestige for the hospital result from the use of Wallace holloware. The value and beauty associated with silver are definite advantages considered by progressive management in making buying decisions.

* * *

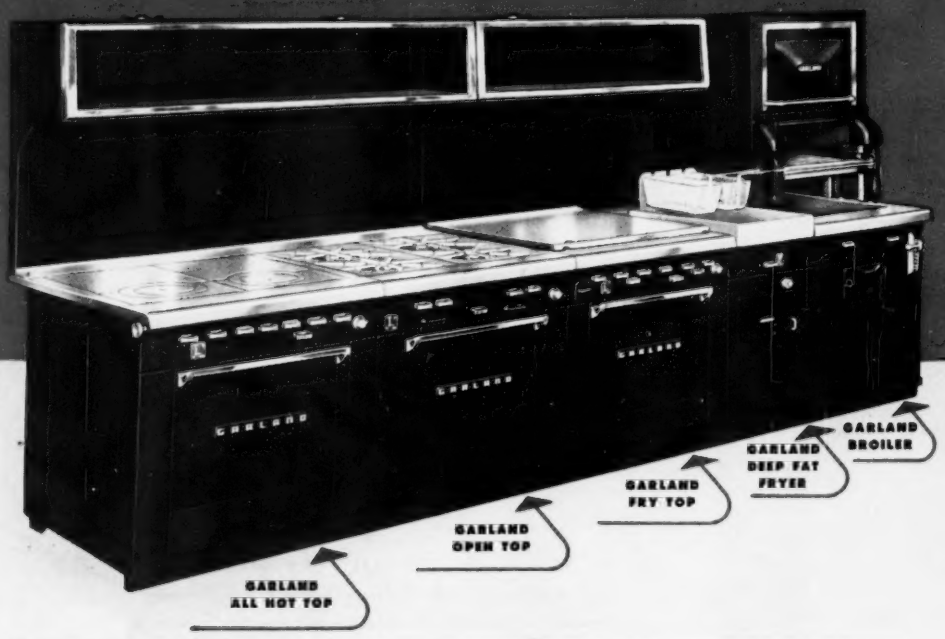
For further details, consult your Wallace Supply Dealer, or write to . . .

WALLACE SILVERSMITHS

WALLINGFORD, CONN.

GOOD PLANNING!

Standardize on Garland-the Leader!



Get lower cost–better efficiency–better appearance!

Get *more* for your investment in heavy duty equipment. Have units precisely aligned—co-designed to match each other—to work together in an organized battery. Your whole kitchen staff will work better. You'll have a more productive kitchen.

Start now with one or more Garland units.

The Garland line is *first in sales* because it is *first in value.* When you buy Garland, you buy the line that kitchen operators everywhere place first. *Proof*—that your choice of Garland is the *right* choice!

Leading dealers everywhere handle the Garland line. See your nearest one now.

All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.

GARLAND*

THE TREND IS TO GAS FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
Roasting Ovens • Griddles • Counter Griddles

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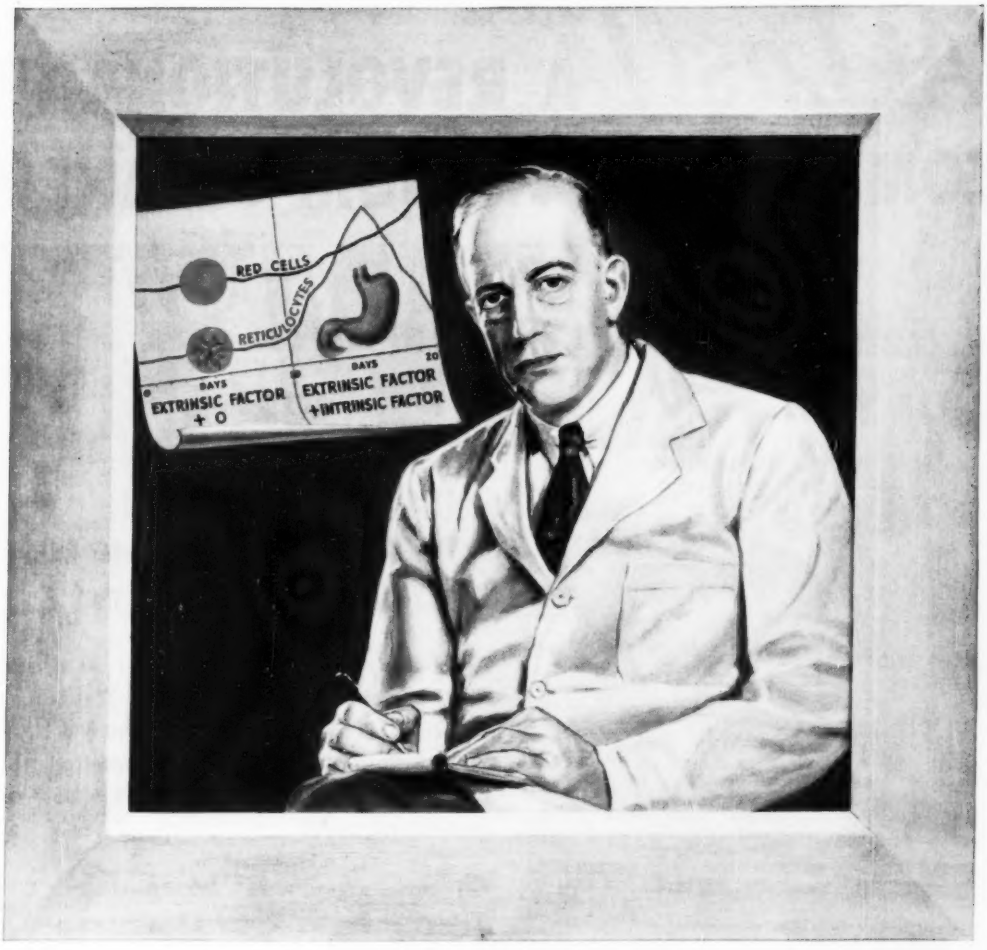

Dr. William B. Castle, 1897–

Dr. Castle was graduated by the Harvard Medical School in 1921. Four years later he began a career in clinical investigation in the field of blood diseases at the Thorndike Memorial Laboratory of the Boston City Hospital. Today he is director there and Professor of Medicine in Harvard University.

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When to Beg for Funds

Question: Is it good administrative practice consistently to "run in the red and beg for aid" from the community?—J.P.B., Tenn.

ANSWER: Usually the hospital that is consistently running in the red is losing money on indigent patients for whom city, township or county agencies make payment at less than actual cost. Accurate accounting of such cases has generally revealed that a large part of the voluntary hospital's deficit may develop at this source. When this is the case, all the facts should be presented to the responsible government agencies in an effort to establish payments for indigent patients at or near the actual cost of their care; when such efforts fail, the hospital is well advised to take its case to the community in a well planned public relations effort—not so much in an attempt to raise funds in this case as in an effort to establish fiscal operations on a sound permanent basis.

In most communities, however, a certain amount of charitable work is done by the hospital itself and may account for the "consistent deficits" mentioned in the question. In this case again the hospital is justified in making its situation known to the community and in asking for aid.

Whenever deficits are caused by a schedule of rates and charges to paying patients that is out of line with operating costs, the hospital must plainly adjust its accounting and financial operations to a self-sustaining basis before it is justified in asking for community aid.

Divided Nursing Staff?

Question: A question has arisen concerning the immediate control of the operating room nurses and supervisor. Is it advisable to have the operating room nursing personnel under the supervision of the director of nursing of the hospital, or under the supervision of the operating room supervisor, who, in turn, does not have to answer to the supervisor of nurses but only to the hospital administration? (It is our feeling that there is too much conflict between operating room nursing personnel and the supervisor of nurses for the whole hospital, and that if these two departments were separated, the functions and the administration of the operating room staff would be far smoother.)—M.T., Iowa.

ANSWER: When one considers such factors as the rotating of student nurses through the operating room, the necessity of training graduate nurses from the regular staff to be ready to go into the operating room, the inevitable connection between patients coming from nursing units to the operating room and returning to nursing units, it seems that the operating room supervisor should always report to the director of nursing service. There is no reason why this should cause conflict; on the other hand, if the organizational setup is sound and thoroughly understood by all, it actually should result in a smooth operating setup.

There are some few hospitals in which the operating room supervisor reports either to the administrator or to his first assistant. However, the vast majority of hospitals have the operating room supervisor reporting directly to the head of the nursing service.

Reducing Late Charges

Question: How can we eliminate or at least reduce late charges which have to be sent to patients after they leave the hospital? —B.C., Wis.

ANSWER: There are, of course, many ways to overcome this problem. Depending upon the size and layout of the hospital, such mechanical helps as tube conveyor systems, electric writing machines, and others that afford rapid communication between the point of origin of the charge and the cashier's cage will help a lot.

There is one very simple method which has proved most effective in hotels. When the patient or relative appears at the cashier's cage to make the final payment of the bill before the patient goes home, the cashier should ask: "Have you had any services today, such as laboratory test, a prescription filled, an x-ray, a physical therapy treatment?" The patient's answer to this question will often give the direct lead which will allow the cashier to get the late charge posted before the patient goes home. Nothing is more annoying to a patient than to think a bill is paid completely and then to get two or three charges later on.—E. W. JONES.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Question of Propriety

Question: Is it proper for the hospital administrator to be a member of the women's auxiliary? If she is not a member, who presents auxiliary plans and programs to the hospital board for approval?—R.M.S., Ind.

ANSWER: Since the auxiliary by definition is an adjunct agency rather than a part of the hospital organization itself, the relationship of the administrator to that body would seem more properly to be an *ex officio* one; however, no serious impropriety is involved in making the administrator a member provided she does not hold office or dominate the organization. In most instances, the president of the women's auxiliary or some other officer of that group should be a member of the hospital board, thus establishing a regular channel of communication between the two bodies.

Eligibility for Care

Question: How far should the outpatient department investigation of applicants go toward protecting the hospital and its physicians from abuse by patients who are able to pay a private doctor?—M.B.L., Wyo.

ANSWER: Where the outpatient department is established as a charitable agency and staffed by physicians who donate their time and services to patients who are requesting and presumably requiring charitable care, full investigation by a competent social service worker on the staff of the hospital, or use of social service records developed by other public or private agencies in the community, is justified to determine eligibility for private care. In most cases, the hospital will find patients not on relief rolls able to make some token payment for service and most authorities consider that a "charge according to means" on the basis of the social service findings is the best procedure.

Where investigation reveals a patient able to afford private medical and hospital care on the basis of commonly accepted practice in the community, the applicant should be so informed by the social service worker. Requests for care of emergent conditions are, of course, exceptions to the foregoing procedure.

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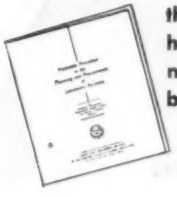

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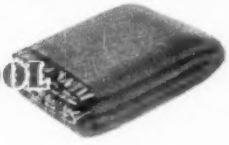

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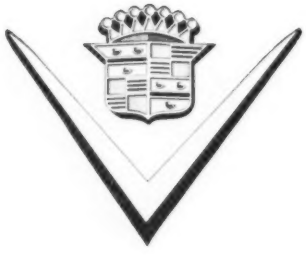

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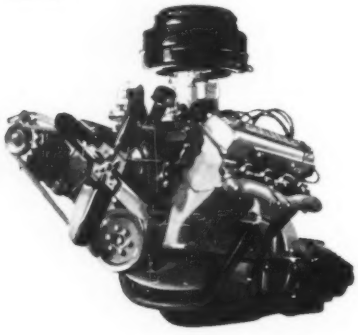

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Looking Forward

Creaming at Cleveland

"YOU always wrong side fence?" asked our friend Anastasia, who paid us a post-convention visit not long ago. She was referring, it developed, to the Protestant hospital association's decision to hold a separate meeting in March—notwithstanding our editorial efforts to show that there are too many hospital conventions already.

We had several answers: It wasn't really an additional meeting, but simply a change of schedule. You couldn't blame the association for wanting independent standing. This had nothing to do with the principle stated in our editorials. The decision didn't prove us wrong, or out of step.

Anastasia listened and left. A few minutes later our telephone rang. It was Anastasia. "Horseradish," she said. "You got creamed."

Prophecy

IN HIS prophetic essay on representative government, John Stuart Mill warned that a bureaucracy must ultimately perish—"by the immutability of its own maxims." As a fine illustration that Mill was right, we offer the case of the midwestern doctor who found himself, for reasons that are not important here, separated from the staff of his community hospital. An energetic man with financial resources and financially resourceful friends, the doctor bought himself a piece of land near by and started to build a hospital of his own.

When the bricks were shoulder high the money ran out, whereupon our doctor promptly applied for federal funds under the Hill-Burton Act. On the ground that no additional facility was required for the area, his request for aid was turned down. "We build hospitals only where hospitals are needed," said the maxim, undoubtedly an excellent one for a public health agency.

Wise in the ways of government and politically as well as fiscally sophisticated, our man then changed hats and went to Washington, where he asked the Reconstruction Finance Corporation for a loan and got it. "A hospital is just like any other business," said the maxim—probably a sensible one for a public banking agency.

Now the roof is on the building and the pipe is in the ground. The left hand knoweth not what the right hand doeth, and the immutable maxims grind on toward the final, inevitable impasse.

Nominations

AS CHAIRMAN of the committee that has been developing a program for the study of hospital costs to be conducted by the American Hospital Association's Commission on Financing Hospital Care, Dr. Arthur C. Bachmeyer has made a notable addition to the long list of his contributions to American hospitals. Reporting to the association's house of delegates at Cleveland, Dr. Bachmeyer said the committee estimated the study would take two years and cost $500,000. With the aid of the National Foundation for Infantile Paralysis, it was explained, the committee has prepared a presentation of the study program for the foundations which are being asked for funds to support the project.

As explained by Dr. Bachmeyer, the study will seek to evaluate the current financial position of hospitals from every possible angle. Among the important areas to be explored are the various factors affecting hospital expenses, such as elements of operation and use of facilities, standards of quality and efficiency of service, med-

ical practice, educational and research programs and standby or readiness-to-serve costs; the sources of hospital revenues, including trends in prepayment plans, government payments, philanthropy, payments by patients and community agencies, and rate setting practices; needs and demands for hospital services; hospital-physician relationships, and many other factors affecting the hospital economy. The study will include all types of hospitals, Dr. Bachmeyer said, but attention will be focused on the voluntary general hospital, where the major share of the nation's hospital care is rendered and where the problem of continued financing is most acute.

Inevitably, many of the judgments to be made by the new commission must necessarily emerge from an appreciation of human needs as well as from study of demonstrable fact. In these areas, especially, conclusions will be susceptible to bias according to the political and social philosophies of the interpreters. Obviously, fine objectivity and high moral integrity on the part of the project's staff will be essential to the success of its mission.

Dr. Bachmeyer's understanding of all elements of the complicated national hospital structure, his dispassionate wisdom and his unquestioned devotion to the cause of better hospital care would make him the logical choice as general director of the project. As chief executive officer of the study, Dr. Eli Ginzberg of Columbia University would also make a distinguished contribution, as he has done in the study of nursing function and in the New York State study of hospital financing about which he spoke at Cleveland. The latter project, particularly, has given Dr. Ginzberg a grasp of problem and method that would be invaluable in the work to be done now.

Just as the studies made by the Commission on Hospital Care have significantly altered the distribution of hospital facilities in the United States, the results of this tremendously important new project may have a bearing on the whole future course of voluntary hospital operation. The nation's hospital needs could not be met better than they would be by Dr. Bachmeyer and Dr. Ginzberg if they were selected and could be persuaded to serve.

Monsieur Vincent

IT IS unlikely that all the public relations talent now at large in the hospital field can do as much in a year to win friends for hospitals as the moving picture "Monsieur Vincent" can do in an hour. With an effectiveness that posed or acted pictures and synthetic copy can never achieve, this simple, true story of the life of St. Vincent de Paul transmits the essence of the voluntary hospital. Produced in France and thus refreshingly free of the Hollywood touches that make most hospital movies and publicity or "educational" films so painful, the picture shows St. Vincent doing Christ's work among the sick poor.

The truth that is taught by St. Vincent and his devoted *Filles de la Charité* is a simple one: In the care of the sick, neither riches nor skill can replace love. In contrast to many who do hospital work today, St. Vincent neither sought nor expected gratitude from those he aided. The greatest triumph of his spirit, in fact, was his tender, encompassing love for those who abused him even as he ministered to their needs. Here is an eloquent lesson for doctors, nurses and hospital administrators.

Quality of Greatness

SINCE the time of Hippocrates, the hallmark of the truly great physician has been that in addition to his professional attainments he has had the humility of the philosopher. Hippocrates revealed his greatness in his famous first aphorism: "Life is short and the Art long; the occasion fleeting; experience fallacious, and judgment difficult."

Humility was apparent throughout the writings of William Harvey, who took little credit to himself for his surpassing triumphs of scientific observation and reasoning. In modern times Sir William Osler, whose 100th birthday was celebrated last summer, made the greatest of all his many contributions, the introduction of bedside teaching at Johns Hopkins, by recognizing that textbooks written by himself and his colleagues had little to offer compared to actual observations of nature and God at work in the human body.

In a lighter vein, the contemporary British physician-philosopher James Bridie has described the picture by Luke Fildes which has recently been given such wide circulation as showing "a middle-aged man scratching his beard and wondering what the devil is the matter with a sick child he is expected to cure." In the passage that follows, Bridie reveals his understanding of the quality of greatness in medicine: "That is the master-condition of all honest men who live by the practice of medicine—'What the devil is the matter?' they ask themselves continually from the lobby to the bedside; from the bedside to the postmortem room, and after that. When that questioning of the soul is answered or ignored, we know that the devil himself has taken the wicked doctor into his keeping."

In one of his philosophic essays, Albert Schweitzer, who must certainly be counted among the greatest of living physicians, has stated his concept of the doctor's duty: "Whoever among us has through personal experience learned what pain and anxiety really are must help to ensure that those who are in bodily need obtain the help which came to him. He belongs no more to himself alone; he has become the brother of all who suffer. On the 'Brotherhood of those who bear the mark of pain' lies the duty of medical work, work for humanity's sake."

Pride and arrogance are enemies of the hospital administrator no less than the physician; in one as in the other, humility is the hallmark of greatness. Like the doctor's Principles of Ethics, the administrator's creed should include the warning that "Self-laudations defy the traditions and lower the moral standard of the profession."

In the board-administrator relationships

HOSPITAL TENSIONS THREATEN TENURE

RAY E. BROWN
Superintendent
University of Chicago Clinics
Associate Professor, University of Chicago

ONE of the chief characteristics of the hospital administrator is the rapidity with which he changes his locale of operations. This rapid turnover in hospital executive positions is in marked contrast to the longevity of tenure which obtains in the ranks of top management in other types of enterprise. Some part of this contrast can be explained by the aspect of ownership control sometimes enjoyed by management in enterprises organized for profit. That explanation is not adequate, however, inasmuch as the most striking development in modern business enterprise has been the evolution of management as a profession and the consequent divorcement of management and capital.

There are many reasons that could be given for the relatively short tenure of hospital administrators. The reasons most often advanced are concerned in one way or another with a failure in administrator-board relationships. Too often an attempt is made to blame an administrator's resignation on the shortcomings of either the board or the administrator. Obviously, no such generalizations can be accepted unless one is prepared to believe that the people who serve as hospital board members and those individuals who choose careers as hospital administrators are in general less able than the rest of the population. Anyone familiar with the composition of either group will readily, and with complete justification, argue that in general the reverse is true.

A majority of the problems of administrator-trustee relationships grow out of the peculiar situations involved rather than out of any peculiarities of the personnel involved in the situations. The hospital trustee-administrator relationship is subject to extraordinary tensions that are not common to other types of enterprise. The existence of these tension areas is

Seven photographs by William Rittase, Philadelphia. Courtesy, St. Luke's Hospital, New Bedford, Mass.

too often not recognized by either party concerned.

Some of the factors causing these tensions are inherent in any social agency. The fact that social agencies are nonprofit helps create an environment of insecurity in that the chief standard by which the success of management is usually measured is removed. Profits are not only a familiar yardstick but they are a most objective and an easily interpreted means of determining accomplishment. Board members of social agencies have often been criticized for the emphasis they have placed on the financial aspects of such agencies. This emphasis has not always represented a failure to realize the social purposes of the agency, but rather the utilization of an objective standard because of the difficulties involved in evaluating social accomplishment. Other than a purely statistical analysis there is little that can be appraised about a social agency but what involves elements of subjective judgment.

PROBLEM IS INTENSIFIED

The fact that the usual board member is by training more competent to judge financial results intensifies a problem peculiar to hospitals as social agencies. By tradition many communities have forced the voluntary hospital to bear a large share of the costs of hospitalization for those unable to pay. Any reasonable opportunity for continuing solvency is obtained only by overcharging and shortchanging the patients who can pay. This latter group, very often friends and associates of the trustees, quite properly become vocal over the high rates charged and critical of the services which the hospital is able to furnish them. In fairness to hospital trustees it should be stated that most of them realize that such a situation exists. They, however, have been powerless to correct the cause by having the community shoulder the full costs of its indigent citizens. The vexing problem of inadequate finances, humanly enough, colors the board's thinking on other problems the hospital faces and handicaps the development of confidence in the administrator. The administrator has the same reaction. He sees the futility of attempting to develop a better program when the dollars are not available to support the existing one.

There are other important tension areas that are unique to the hospital. No other form of organization can equal the obstacles to tranquillity that are present in the medical staff-administrator-trustee triangle. The picture of third party independent contractors responsible for specifying the services rendered to the clientele of an enterprise, at once dependent upon the enterprise for carrying out their orders, but independent of the enterprise in their relationship with the enterprise's clientele, is not found in any other type of enterprise. While they are not stockholders in the hospital they have a deep abiding proprietary interest because their livelihood to an ever increasing extent is dependent upon the hospital.

This dependency is in turn accentuated by the natural competition between individual members of the medical staff. Each individual member of the staff has good reason to weigh the effects of each act of the hospital in terms of the effects upon himself. The fact that the medical staff often moves in the same social circle as the board members gives the staff member an exceptional opportunity to register any feelings of displeasure toward the administration of the hospital. He doesn't have to register any feelings of displeasure directly with a member of the board. Inasmuch as he is likely to have the same friends as the board members have it is necessary only that he express dissatisfaction with the hospital's management to his friends. The results are perhaps more effective because a second person relays information on to the board members.

Some causative factors represent a paradox. It is widely accepted that board members should be broadly representative of the various cultural and economic groups that compose the community. This diversity is necessary to assure the community that the hospital's policy-forming board will be fully aware of the needs and desires of the total community. Such heterogeneity, however, can be a force against stability if the members of the board do not carefully avoid allowing their special representation to rule their evaluation of the hospital's work. It may affect stability also because it can prevent the formation of long-run established policy. A favorable climate for proper administration requires a fair measure of predictability of board attitude and board reaction. A hazard created by diversity lies in another direction. If the interests represented on the board are too divergent it is possible that group agreement will be difficult. This is one of the conditions under which dominating personalities assume control of an organization.

Some board members are quite properly chosen because of the special experiences and knowledge they possess. The hospital as an enterprise is engaged in numerous activities in any one of which a member of the board may be a specialist. Because board members do possess special knowledge of a particular department of the hospital they may tend more closely to scrutinize that operation. Only conscious restraint on the part of the board member may prevent him from seeing such an operation as an isolated activity, forgetting that it operates as a unit of a synchronized complex, forgetting also that the administrator cannot duplicate the full-time concentration the board member is able to devote to his own specialized business.

The fact that the board member has a larger interest in one of the hospital's activities sometimes leads to over-support of the particular department. Such over-support means that another department receives a disproportionate share of the limited resources available for the total work of the hospital. When the neglected departments deteriorate to the point that staff or patient criticism becomes acute the administrator is likely to be severely blamed because the disparity in efficiency is more marked. Under these circumstances it also is easy for the trustee's special knowledge and interest to lead him across the line dividing policy formulation from policy execution.

INVOLVED IN ADMINISTRATION

Individual members of the board may slip unconsciously into involvement in details of administration. Their social contacts with the medical staff has already been mentioned as a factor. In their business life, through their churches and clubs, and in every contact they have they are subject to having favors asked because of their known position on the hospital's board. It is difficult for the board member to recognize that as a trustee he functions as a member of a policy forming group and that once the group has determined policy properly he should act only through the employed administrator. Often he is tempted to make commitments rather than explain this difference between ownership and

trusteeship to those who request favors.

The administrator sometimes paves the way for board interference in matters of administration by refusing to accept responsibility for decisions in matters on which board policy is clear. Such continued referral of purely administrative problems to the board for final decision is quite different from advising with the board on those decisions that may bring substantial reaction from the parties affected. The one represents administrative default while the other recognizes the value of the board as a depository of experience. The hypersensitivity of some board members to popular opinion regarding the hospital acts as a strong force toward causing the administrator to shy away from administrative decisions that may cause loud but quickly passing noises. The administrator who habitually shies away from the hard decisions has only himself to blame when the board takes his habit for granted.

ADMINISTRATOR TRESPASSES, TOO

Much stress has been placed by hospital administrators on the seeming proclivity of trustees to interject themselves into the area of actual administration. It is doubtful that as much of this transgression occurs as the complaints of administrators would seem to indicate. A close study of several ruptures in trustee-administrator relationships shows that an indictment can just as often be made of the administrator trespassing over into the realm of policy making. There are aspects surrounding the hospital that are peculiarly favorable for the development of dictatorial tendencies in the best balanced of administrators.

The growing practice of restricting the tenure of board members is one of these. The practice has great merit but it cannot be denied that it seriously affects a primary board function of furnishing continuity to the organization. It encourages the administrator to take over the reins inasmuch as new board members are unfamiliar with the hospital organization, are hesitant to speak out, and too often are tempted to accept a situation rather than spend the substantial amount of time required to learn the things that an old board member probably had just learned at the time he was replaced.

Then there is the fact that the hospital is such a complex of activities that it gives the administrator a solo rôle as being the only person possessing anything like an intimate knowledge of the whole. It is easy for him to become impatient with those who question his actions since many such questions show the questioner is seeing only a part of the total problem the administrator faced when he acted. Because of this fact the board member is likely not to ask questions. The unanswered question remains, however, and to it are added many other questions that fester because they are not permitted to drain clean through the natural process of being aired and explained.

A corollary to this is found in the board chairman who by virtue of long years in the chair, a consuming interest in the hospital, and an aggressive personality secures a double hold on both the policy forming and administrative functions of the hospital. Frustration and early resignation on the part of the administrator serve only to strengthen the already strong hold such a chairman has on the executive functions inasmuch as the lack of administrative continuity actually forces the chairman to run the hospital during interim periods between administrators.

There are other features about the hospital that lead administrators, and board chairmen as well, to develop one-man shows. The practice of appointing socially prominent and wealthy persons to board membership irrespective of other criteria often results in majority disinterest. The attendance record of too many boards reflects just such a condition. Irregular attendance prevents the disinterested board member from being informed on the hospital's affairs. Over a period of time the failure of board members to participate in the work of the board leaves no alternative but for the decisions to be made without reference to them. The habit of acting without board concurrence is not hard to develop under such circumstances.

The emergent and around the clock nature of the hospital quite often presents the administrator with opportunities for spot decisions. It is easy for such legitimate instances to wear a pattern as well as to develop a taste on the part of the administrator for a quick draw. The board is placed in an awkward position in any attempt to challenge any particular instance and consequently allows policy formation to occur through the informal process of accumulated administrative decisions. It can be suspected that this is one of the reasons some hospitals have never developed formal policies. Well conceived and written policies cramp the style of the administrator who prefers to ad lib his policies as he goes along.

The fact that the hospital administrator heads an organization which by tradition, and to a large extent by necessity, is characterized by the rigid discipline required all down the hierarchy may lead to the administrator's having a top sergeant complex. He becomes accustomed to what almost amounts to push-button management. In such an environment it is easy to develop notions of grandeur. The inevitable result of such notions is a collision with the board or the medical staff.

It might be that this factor has something to do with the commonly observed practice of all news from the hospital being announced in the name of the administrator. The general practice in other enterprises is for news releases covering policy matters to be given out over the name of the board chairman. Full adherence to such a policy is not recommended for hospitals. It is suggested, though, that it is easier to get someone to share the failures if they have also been allowed to share the honor and the glory.

MAJORITY ARE HAPPY

Throughout this discussion I have perhaps painted such a negative picture that one would wonder if any administrator ever enjoys a happy and satisfying relationship with his board. The facts are that the larger percentage of administrators do have such a relationship. There are many examples of administrators serving the same hospital throughout their entire administrative career. Evidences of that sort do not mean that the same pitfalls to an amicable and productive relationship do not exist in those institutions. It does mean that hazards have been recognized and avoided.

The responsibilities of a hospital trustee are large. And so are those of a hospital administrator. The largest responsibility of both, however, is to understand the rôle of the other. The general high level of competence of both groups should assure such understanding when both recognize the peculiar hazards to understanding involved because of the nature of the hospital as a medical and social enterprise.

Isn't it about time for hospitals to

INVESTIGATE THE INVESTIGATOR

GEORGE R. GERST, M.D.
Surgeon, New York City

IT HAPPENS frequently in our better hospitals these days that they have thrust upon them considerable sums of money for the purposes of medical research. In other instances, this money is solicited with a specific problem in mind and with qualified investigators to attempt a solution of it. In many cases, however, money is donated out of sheer philanthropy on the chance that it will further the cause of medical research.

In most instances the hospital that is fortunate enough to receive such a gift publicizes the news in the hope that qualified workers will come forward to justify it. The most typical instance is the area of cancer research within the broad field of investigative medicine. Before long the response makes itself felt. One can always find applicants who are fascinated by such opportunities and eager to play their part, however humble it may be. Many of them carry the endorsement of other institutions of learning.

Many institutions for the care of the sick are not geared to anything but the most elementary form of medical investigation, which is seen as a by-product of bedside service. The cancer problem, for example, has infinite ramifications, reaching far beyond the hospital. While adequate medical and surgical talent may be available for routine purposes locally, it is another matter to have the proper facilities as well as the proper scientific talent applied to the right kind of clinical material.

Unfortunately, the public is not aware that funds for basic scientific research are too frequently used for the investigation of the malignant neoplasms that can in no way lead to substantial results. For example, one finds funds used to justify fellowships for their own value in teaching promising young students of medicine the technics of research, particularly in the evaluation of palliative cancer therapy. Important as this may be, it is not the original intent of a generous contributor who had much more in mind and who, if he knew, would certainly want his money used in a much broader attack on such a destructive phenomenon in human society.

NOT A HOSPITAL PROJECT

Basically, the problem of malignant disease is not primarily the problem of the clinician working in the hospital, as much as it is the problem of the man working in the laboratories and in the basic sciences. The practicing physician can contribute little toward the solution of this problem. It takes the combined efforts of the clinician and the pure scientist, whether he is biologist, physiologist, biochemist or physicist, to tackle such an elusive goal as that of malignant disease.

The traditional training of the physician consists of a premedical course, a medical course, a graduate internship, sometimes a year in the laboratory, but more often a graduate residency. During this period of time he does not, with few exceptions, master the principles of basic scientific disciplines, nor does he master the various technics that make the goal of successful scientific research so difficult of achievement. As a result, the physician who has received this training may be an excellent clinician, but not necessarily a basic scientist.

It must be emphasized here that we are discussing the problem of cancer research in a fundamental way, particularly as to etiology and not necessarily for the palliative treatment of a dreaded disease. Nor are we emphasizing the collection of clinical data for statistical purposes, social, medical or vital. These aspects of research do not require the depth of mind and comprehensiveness of effort for which we are pleading.

Much can be accomplished in our attempt to determine the basic factors in the case. To begin with, we must investigate our investigators more carefully, going beyond and consulting with our advisers as to how money can be expended these days for such purposes to the best possible advantage. Qualifications must be examined far more carefully than has yet been done.

PERIODIC EXCHANGE OF IDEAS

It should be of great advantage for scientists to pool their efforts, on either a nationwide or local scale, and create a cancer research board for the purpose of planning, organization and continuous deliberation in order that basic problems may be outlined in accordance with the best traditions of scientific medicine. The paths of investigation should be laid out in accordance with the ability of the hospital and of selected scientists to follow them. Coordination of effort should not be attempted by haphazard organizational devices. Research deeds do not necessarily keep pace with research desires. It takes more than ambition in a hospital to produce achievement.

Periodic meetings for the purpose of consultation and mutual help should be arranged at frequent intervals during which ideas can be freely exchanged with a view toward channeling and, if necessary, redirecting the various efforts that must go into such a diversified field as cancer research. This process should continue until the problem is solved, and the problem will be solved much sooner if we follow the rules of logic rather than of emotion in our efforts.

The 250 bed General Rose Memorial Hospital, Denver

The First Completely Postwar Hospital

MILTON H. HOFFMAN
Former Director of Public Relations
General Rose Memorial Hospital, Denver

THE nation's first completely postwar hospital opened its doors to patients last March, climaxing a four-year drive for funds, building production, and equipment.

The General Rose Memorial Hospital in Denver was started in the spring of 1945, following the death in Germany of Maj. Gen. Maurice Rose, son of a Denver rabbi.

At that time, there were only 2.9 hospital beds per 1000 population in Denver's eight privately operated hospitals. These institutions could barely carry the normal load, much less accommodate victims of an emergency epidemic or tragedy.

With these facts in mind, community leaders and businessmen organized the General Rose Memorial Hospital and elected Maurice B. Shwayder founding president. Under his inspired guidance, the association collected a sum of money which later financed the $2,800,000 voluntary hospital. Such celebrities as Eddie Cantor, Kay Kyser, and Danny Kaye worked with the group to gather money for the hospital.

On May 31, 1948, Al Jolson entertained a large audience of subscribers at the $1000-a-plate Completion Campaign Dinner. A few hours later, all Denver was shocked to learn that Maurice Shwayder had died, never living to see the hospital completed. In the same way, General Rose was killed before realizing his dream—the capture of Berlin.

Architects Roland L. Linder and Earl C. Morris, consulting with Dr. Herman Smith, Chicago hospital expert, planned the 250 bed hospital to meet four primary objectives: complete comfort for patients; utmost efficiency in operation; safety, and exceptional ease in maintenance.

In the execution of these aims, they exploited scores of technical innovations, including humidity controlled operating rooms; anesthetic induction rooms; piped-in oxygen; electric eye doors, and many others. They abolished the hospital ward, relying entirely upon private and semiprivate bedrooms, each with its own bathroom. A service corridor on every floor enables the housekeeping department to work efficiently without interference or restriction. Separate parking areas are arranged for physicians, employes, delivery and visitors—allowing each type of traffic to enter at the most convenient point.

In each of two penthouses, located on top of the third and sixth floors, fresh air is brought in through self-cleaning filters. This newest method of filtering air takes pollens and microscopic dust and even smoke out of the air. The cleanest air possible is then drawn through heating or cooling coils by fans and then reheated or cooled and blown through ducts to corridors and rooms. Air is blown into all the corridors for ventilation and summertime cooling, and then through the patients' rooms and out the windows. The corridors are thus always fresh and odorless and the rooms are ventilated. An exhaust system from all toilets runs constantly. Eighteen rooms have air conditioning for allergy patients.

In the operating wing, hot air and cold air are brought to each room in separate ducts, and by means of a thermostat and dampers the right proportion of air is passed into the room to hold the temperature exactly right. This air is introduced into the rooms through perforated plates without drafts.

This filtered, cooled air is also brought down from the roof and blown into the kitchen, around the outside of the kitchen hood to cool the kitchen, and from there into the kitchen hood. The exhaust from the hood then passes through filters that remove the grease and the odors are carried through a large underground duct to the boiler room, where two fans exhaust them. In this way, all the cooking odors are carried 300 feet away from the hospital. Live steam can be blown into this duct for cleaning at any time. Most fans are in duplicate, so that when the load is light, only one fan is needed, but when the load is heavy, both are used.

Refrigeration machines in each penthouse are hermetically sealed units using freon refrigerant, each having a cooling capacity of 60 tons.

No air in the hospital is recirculated but is constantly fresh and heated or

(*Continued on Page* 58.)

Lobby. Wainscoting is rose travertine marble; terrazzo floor matches it.

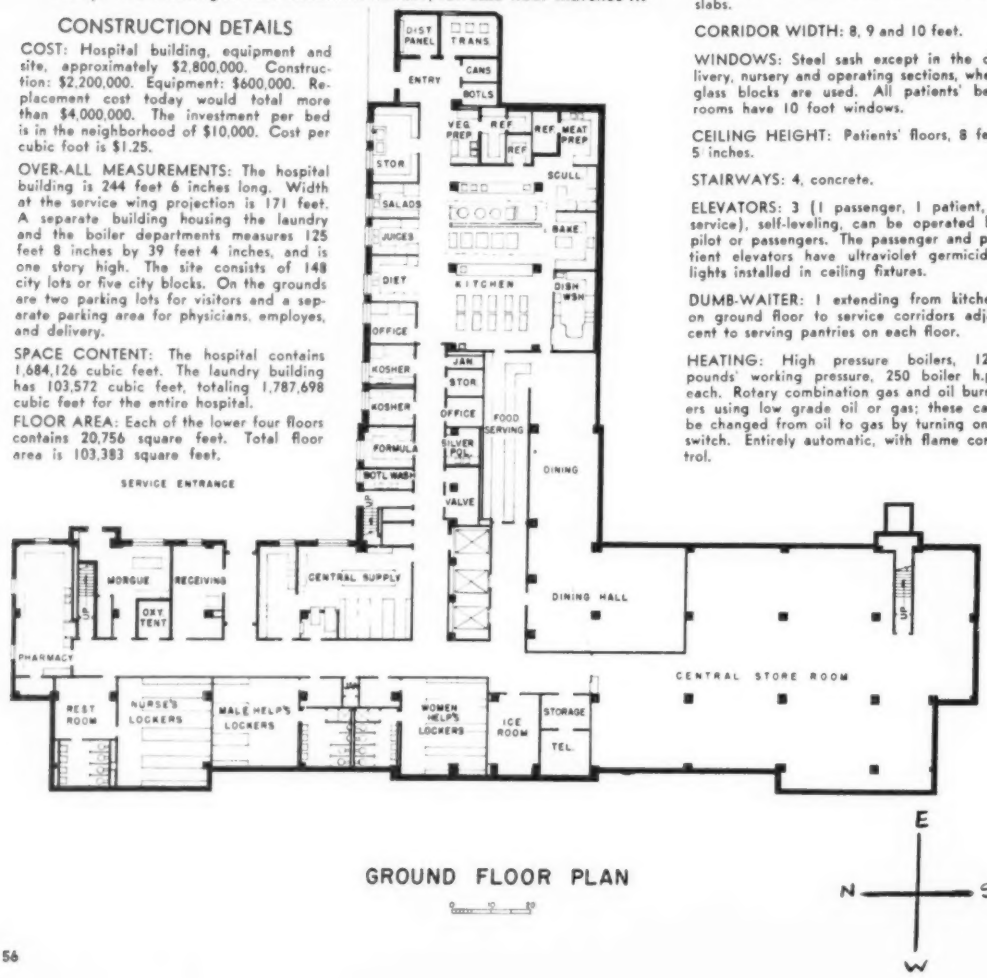
CONSTRUCTION DETAILS

COST: Hospital building, equipment and site, approximately $2,800,000. Construction: $2,200,000. Equipment: $600,000. Replacement cost today would total more than $4,000,000. The investment per bed is in the neighborhood of $10,000. Cost per cubic foot is $1.25.

OVER-ALL MEASUREMENTS: The hospital building is 244 feet 6 inches long. Width at the service wing projection is 171 feet. A separate building housing the laundry and the boiler departments measures 125 feet 8 inches by 39 feet 4 inches, and is one story high. The site consists of 148 city lots or five city blocks. On the grounds are two parking lots for visitors and a separate parking area for physicians, employes, and delivery.

SPACE CONTENT: The hospital contains 1,684,126 cubic feet. The laundry building has 103,572 cubic feet, totaling 1,787,698 cubic feet for the entire hospital.

FLOOR AREA: Each of the lower four floors contains 20,756 square feet. Total floor area is 103,383 square feet.



GROUND FLOOR PLAN

HEIGHT: The front, or main part, of the hospital housing the patients' bedrooms rises seven stories with the ground floor. The service wing, extending back from the center of the main section, stands four stories including the ground floor.

EXTERIOR CONSTRUCTION: Brick facing masonry construction in modern design.

FLOORS, WALLS, CEILINGS: Construction is 95 per cent fireproof throughout. Walls and interior partitions are cinderblock and metal lath, covered with plaster or tile.

Floors are of three materials: first floor corridors are terrazzo with terrazzo wainscoting in emergency, x-ray and laboratory sections; all bedrooms have terrazzo floors in three attractive shades to harmonize with the color schemes of the rooms; in the operating and delivery rooms, terrazzo floors with a metal grid for grounding were installed with terrazzo bases and tile walls. Upper floor corridors have asphalt tile flooring. Quarry red tile, impervious to nearly all types of wear, covers the ground floor and serving pantries.

Ceilings are of acoustical board and suspended tile. In the operating and delivery sections and serving pantries, ceilings are of metal acoustical panels which can be removed for cleaning. Doors are birch veneer slabs.

CORRIDOR WIDTH: 8, 9 and 10 feet.

WINDOWS: Steel sash except in the delivery, nursery and operating sections, where glass blocks are used. All patients' bedrooms have 10 foot windows.

CEILING HEIGHT: Patients' floors, 8 feet 5 inches.

STAIRWAYS: 4, concrete.

ELEVATORS: 3 (1 passenger, 1 patient, 1 service), self-leveling, can be operated by pilot or passengers. The passenger and patient elevators have ultraviolet germicidal lights installed in ceiling fixtures.

DUMB-WAITER: 1 extending from kitchen on ground floor to service corridors adjacent to serving pantries on each floor.

HEATING: High pressure boilers, 125 pounds' working pressure, 250 boiler h.p. each. Rotary combination gas and oil burners using low grade oil or gas; these can be changed from oil to gas by turning one switch. Entirely automatic, with flame control.

Induced draft fans for boilers start and stop with burners. Automatic boiler feed pumps furnish water to either boiler automatically, also heat the make-up and boiler water.

Medium pressure steam is carried in underground conduit to the hospital. High pressure steam is run to laundry equipment. Medium pressure steam run to kitchen equipment, sterilizers, water heaters (kitchen hot water at 180°F. and hospital hot water at 140°F.). Medium pressure steam carried to all fan room coils and radiant heating coils.

Radiant heating steam coils placed under the floor slabs for all operating rooms and nursery. Convectors are used for heating in the rest of the hospital, controlled at each room with a valve and each section of the building from zone control valves. Each convector radiator has a steam trap on the return end; coils are concealed in cases under the windows. All condensate is returned to the boiler room through vacuum pumps. The radiant heat coils, convectors, and air conditioning system work together to heat and ventilate the hospital. Medium pressure steam is always available for the sterilizers, kitchen, hot water heaters and other special uses.

TEMPERATURE CONTROL: Thermostats in de luxe rooms control radiators. The rest of the patients' rooms are controlled as a zone. Each side of the building is a separate zone and an inside-outside themostat controls all the radiators in those rooms. The air conditioning coils in the penthouses, both heating and cooling, are automatically controlled, as are the radiant heat coils for the operating rooms, delivery rooms and nursery.

The operating rooms, delivery rooms, labor rooms, and nursery are supplied with air, either heated or cooled as the room may require, controlled by the thermostat in the room. The humidity is controlled by a lever. In case very high humidity is needed in a hurry for an operation, the control lever can be moved and live steam can immediately be introduced into the duct to raise the humidity.

PLUMBING: All plumbing fixtures and hospital equipment must be connected. Hot water is heated in the ground floor heater room and circulated through the hospital so it is instantly available. On the hot and cold water mains, air cushions are installed to prevent a water-hammer when a faucet is turned off suddenly.

Special distilled water lines are installed and special fixtures are connected for the laboratories.

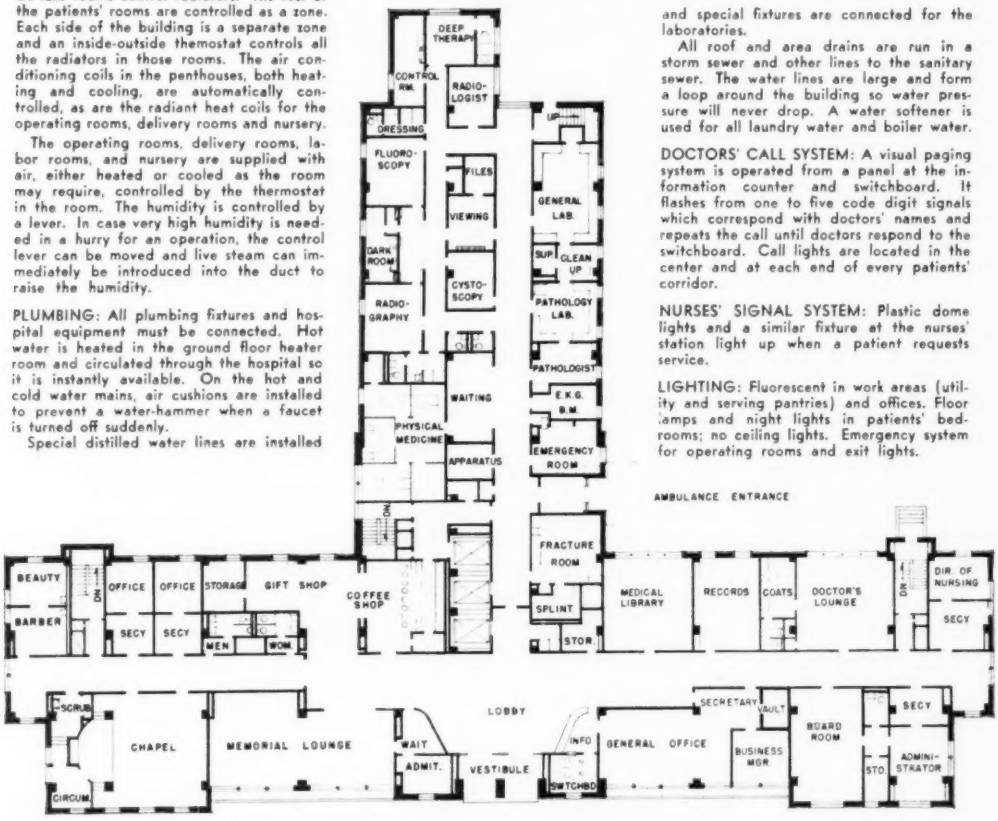
All roof and area drains are run in a storm sewer and other lines to the sanitary sewer. The water lines are large and form a loop around the building so water pressure will never drop. A water softener is used for all laundry water and boiler water.

DOCTORS' CALL SYSTEM: A visual paging system is operated from a panel at the information counter and switchboard. It flashes from one to five code digit signals which correspond with doctors' names and repeats the call until doctors respond to the switchboard. Call lights are located in the center and at each end of every patients' corridor.

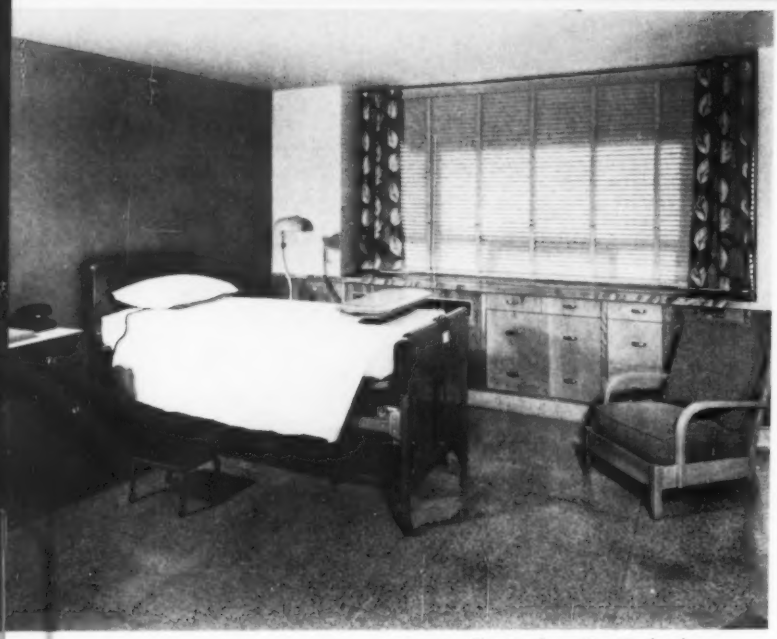
NURSES' SIGNAL SYSTEM: Plastic dome lights and a similar fixture at the nurses' station light up when a patient requests service.

LIGHTING: Fluorescent in work areas (utility and serving pantries) and offices. Floor lamps and night lights in patients' bedrooms; no ceiling lights. Emergency system for operating rooms and exit lights.

Each cubicle in the nursery section contains five or six bassinets.



FIRST FLOOR PLAN



Typical patient's bedroom equipped with built-in cabinets.

cooled to just the right temperature. The exhaust system from the toilets is arranged with long U-bends so that noise will not be carried from one toilet to another.

The hospital is built in the shape of a T. Patients' bedrooms are arranged in the top of the T, while the following service departments are in the base: first floor, emergency, physical medicine, laboratories and radiology; second floor, surgery; third floor, nursery and obstetrics.

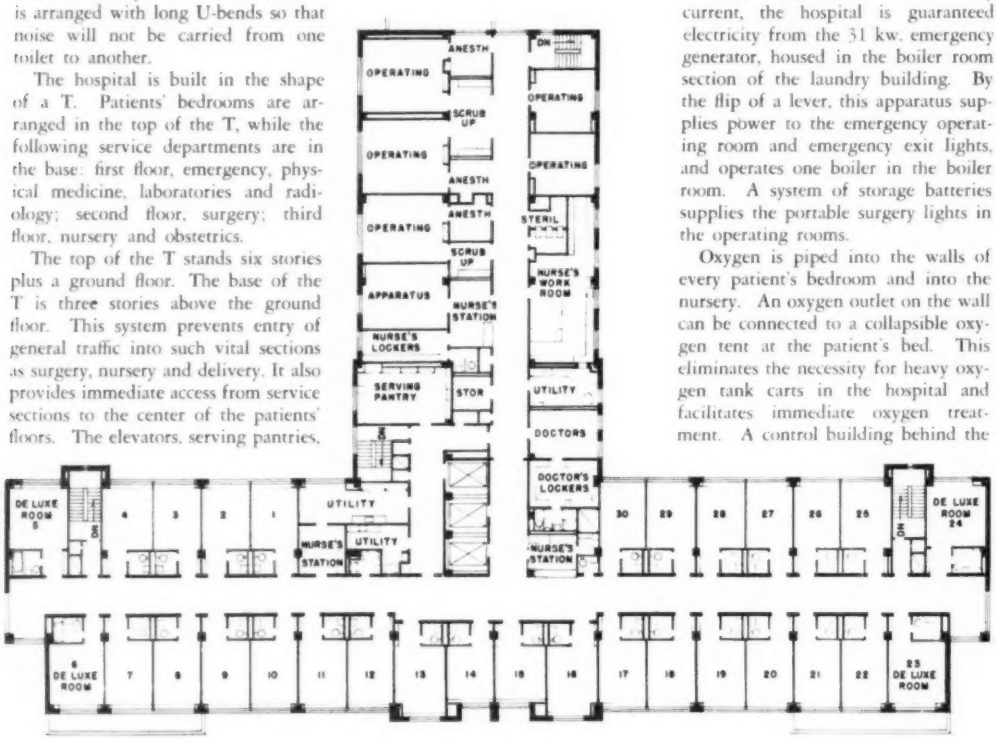
The top of the T stands six stories plus a ground floor. The base of the T is three stories above the ground floor. This system prevents entry of general traffic into such vital sections as surgery, nursery and delivery. It also provides immediate access from service sections to the center of the patients' floors. The elevators, serving pantries, dressing rooms and large nurses' stations are located centrally where the sections are joined.

There is one large, centrally located nurses' station on every floor. The second and fifth floors have two stations. Each station has a refrigerator, medicine cabinet with sink and narcotics box, charting desk and chart rack. Nurses' restrooms on each floor provide coat room and lavatory.

On every floor in the hospital is a service corridor which segregates the general traffic from activities of hospital personnel. Opening from this corridor are: one large serving pantry containing electric dishwasher, steam table, refrigerator; one service elevator for hauling hospital equipment and provisions; one dumb-waiter; one dressings room; one utility room; one laundry chute; one chute for dirty linens and trash, and one custodial closet containing water faucets, drain, and racks for mops.

In the event of failure of the city current, the hospital is guaranteed electricity from the 31 kw. emergency generator, housed in the boiler room section of the laundry building. By the flip of a lever, this apparatus supplies power to the emergency operating room and emergency exit lights, and operates one boiler in the boiler room. A system of storage batteries supplies the portable surgery lights in the operating rooms.

Oxygen is piped into the walls of every patient's bedroom and into the nursery. An oxygen outlet on the wall can be connected to a collapsible oxygen tent at the patient's bed. This eliminates the necessity for heavy oxygen tank carts in the hospital and facilitates immediate oxygen treatment. A control building behind the



SECOND FLOOR PLAN

hospital regulates the oxygen supply and serves as headquarters for large oxygen supply tanks.

A large ice machine on the ground floor can manufacture more than 8000 cubes of ice daily.

Much of the most recently designed and approved equipment in radiological engineering has been installed in this carefully planned department. Some of the units are the only ones of their kind and size in the entire region:

One 250 kv. deep therapy x-ray machine with hydraulic stretcher, used principally for treating cancer.

One radiographic-fluoroscopic unit, complete with rotating anode tube and motor driven tilt table, 4-on-1 spot film device photo-timed, and reciprocating Bucky, 110 kv.-200 ma.

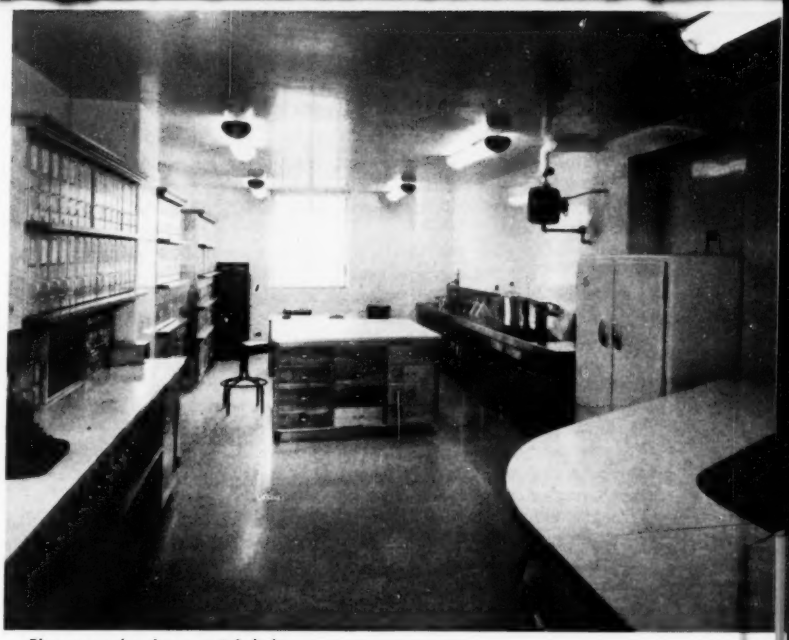
One radiographic machine with cassette changer, rail-mounted tilt table and reciprocating bucky, 110 kv.-200 ma. control and rotating anode tube.

One genito-urological unit for the cystoscopy room; 100 kv.-100 ma. generator hydraulic genito-urinary table.

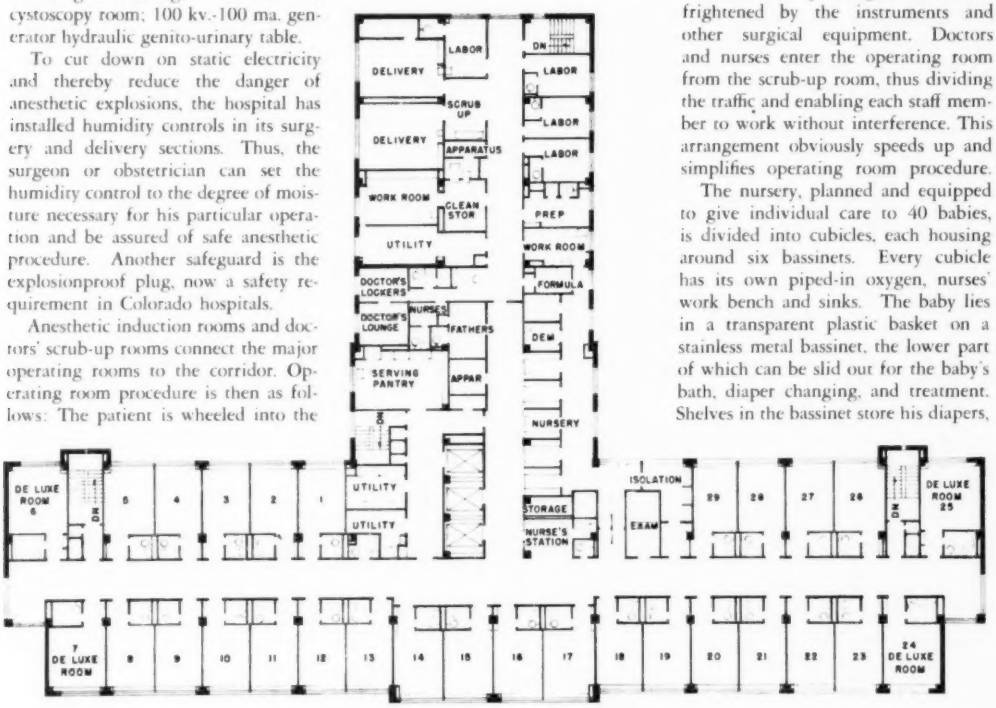
To cut down on static electricity and thereby reduce the danger of anesthetic explosions, the hospital has installed humidity controls in its surgery and delivery sections. Thus, the surgeon or obstetrician can set the humidity control to the degree of moisture necessary for his particular operation and be assured of safe anesthetic procedure. Another safeguard is the explosionproof plug, now a safety requirement in Colorado hospitals.

Anesthetic induction rooms and doctors' scrub-up rooms connect the major operating rooms to the corridor. Operating room procedure is then as follows: The patient is wheeled into the induction room where the anesthetic is administered. In this way, he does not see the operating room to be frightened by the instruments and other surgical equipment. Doctors and nurses enter the operating room from the scrub-up room, thus dividing the traffic and enabling each staff member to work without interference. This arrangement obviously speeds up and simplifies operating room procedure.

The nursery, planned and equipped to give individual care to 40 babies, is divided into cubicles, each housing around six bassinets. Every cubicle has its own piped-in oxygen, nurses' work bench and sinks. The baby lies in a transparent plastic basket on a stainless metal bassinet, the lower part of which can be slid out for the baby's bath, diaper changing, and treatment. Shelves in the bassinet store his diapers,



Pharmacy showing special shelving, work table and cupboard.



THIRD FLOOR PLAN

blankets and clothing, and wheels facilitate his trip to his mother's room. An electric eye automatically opens the main doors to the nursery as the nurse goes through.

Because of a glass wall separating the nursery from the corridor, every baby can be seen by visitors without being moved or disturbed. Germicidal lights, stainless metal fittings, and shatterproof glass help keep the nursery clean and safe. A doctor's examining room adjoining the nursery enables the doctor to examine his young patient without disturbing the other babies. A suspect nursery isolates infants having communicable diseases.

The baby formula room, opening off the main nursery, receives the formulas from the main corridor through a large refrigerator with double sets of doors. The nurse then gets the formula from the refrigerator without leaving the nursery. A dirty diaper vent in the nurses' workroom next door holds the unlaundered diapers, exhausting the odors from the hospital by means of a fan system.

In the delivery section of the maternity department, the four labor rooms are equipped with radiant heating, humidity control and explosion-proof plugs, as are the two delivery rooms for emergency delivery.

The dietary department operates five separate food services which are distinct in personnel, equipment, purchasing and planning. These are the public snack bar; the two kosher services for patients who request this food; the regular patients' trays; therapeutic diet meals for patients, and the cafeteria for hospital employes and staff members. Electrically heated food carts convey the prepared food to serving pantries on each floor, where the trays are made up.

The department is equipped almost entirely in stainless metal, with an all-stainless cafeteria, chef's tables, ranges and sinks. A canopy over the cooking section exhausts kitchen odors to the boilers, where they are disintegrated.

Bedroom furniture is for the most part all metal; beds are of the all-purpose type to ensure comfort for patient and attendants. Another feature of the bedroom is the all-fabric venetian blind, which covers the 10 foot window. This shade does not rattle, is light to operate, and can be completely submerged in water.

Adjoining every patient's bedroom is a private bathroom containing wash basin, toilet and bedpan flushing unit. Each bathroom has a ceiling vent to exhaust odors from the room. The 20 de luxe bedrooms have bathrooms tiled in pastel tints and containing bathtubs, in addition to the standard facilities.

Attractive cove lighting illuminates the nonsectarian chapel. Walls and carpeting are a soft rose color, wainscoting is solid oak. A glass partition separating the chapel from the circumcision room, behind the chapel stage, permits the congregation to view circumcision ceremonies.

One chair will be maintained in the barber shop and the beauty parlor for the convenience and morale of ambulatory patients. Anyone who *looks* better, *feels* better.

Members of the Rose Hospital women's division operate a gift shop for the convenience of visitors to the hospital who forget to bring flowers, gifts or cards. Profits from the shop are used to purchase extra hospital equipment.

Another factor responsible for the early prominence of Rose Hospital is the site, occupying 148 city lots in the heart of a rapidly growing medical center which includes the University of Colorado Medical Center (comprising the state school of medicine and the Colorado General Hospital); the $10,000,000 V.A. hospital, now in construction, and the National Jewish Hospital.

Today, Rose Hospital cares for general medical, surgical and obstetrical patients. It is a nonprofit, nonsectarian institution, 10 per cent of its beds being set aside for charity cases. In addition, it is a participant in Blue Cross and Blue Shield plans.

The Rôle of the Anesthesiologist

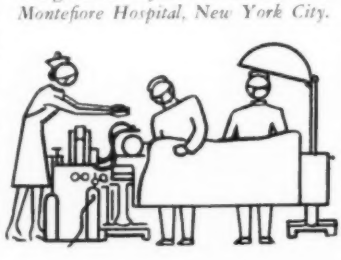
RECENT refinements in anesthesia resulting in the necessity for better trained anesthesiologists are outlined by Ralph M. Tovell, M.D., and Ranald J. M. Steven, M.B., in the *Journal of the American Medical Association* for Sept. 3, 1949, in an article entitled "Anesthesia and the Rôle of the Anesthesiologists of Today."

The authors point up the value of the preanesthesia history and physical examination by presenting several of the newer testing procedures, such as blood and plasma volume, maximum breathing capacity, walking ventilation and differential bronchospirometry. They also offer new interpretations of the hematocrit reading, fluoroscopy and the electrocardiogram. The rôle of the antihistaminic agents in the prevention of postoperative atelectasis is also mentioned.

The actual administration of the anesthetic has progressed with the introduction of combined intravenous and spinal anesthesia which satisfies the surgeon and lessens the psychic trauma to the patient. Mention is made of the intravenous use of procaine in conjunction with general anesthesia to avoid cardiac irregularities, pathological or traumatic. Procaine is also used with thiopental (pentothal) for intravenous anesthesia in bronchoscopies and thoracoplasties.

The rôle of the anesthesiologist in the postoperative care of the patient is facilitated by the use of the recovery room. The authors recommend a ratio of one nurse to four patients in this open ward, provided adequate auxiliary help is available. Among the postoperative medications reviewed, special attention is given to meperidine (demerol) and procaine.

The authors state that the anesthesiologist should be financially and professionally independent. They believe that he should not be an employe of the hospital and they condemn the Blue Cross contracts that predispose to this arrangement. The department of anesthesiology should not be a stepchild of the department of surgery. The authors maintain that "dictation by surgeons should be replaced by unhampered consultation, with decisions reached on purely clinical grounds."—JOHN D. THOMPSON, *Montefiore Hospital, New York City.*



BED REST: *a program for rheumatic fever patients*

JEAN PHIMISTER, R.N.
Superintendent
Children's Heart Unit of Victoria Foundation, Inc.
Morris Plains, N.J.

THE cardiac status of patients eligible for inpatient care at the Children's Heart Unit of Victoria Foundation, Inc., Morris Plains, N.J., is the classification established by the American Heart Association as Grade I, II and III. The criteria for diagnosis and the presence of rheumatic activity, in use by the medical staff of this hospital, will be made available to personnel of any hospital wishing to have them.

Bed rest during the active stage of rheumatic fever is the one point of unanimous agreement among all the authorities on this disease. It is also agreed that evidence of cardiac changes will occur after the cessation of clinical evidence of rheumatic activity. Therefore, the treatment of active rheumatic fever is not complete until the patient is progressively brought up to normal daily physical exertion. In our experience, the average time required to accomplish this treatment is five months. The grading of physical activities for the patient who improves without complications is as shown in figure 1.

Fig. 1: Grading of physical activities for the patient who is showing improvement without complications.

Fig. 2: Occupations found most satisfactory in meeting the child's needs and limiting activity.

The means of achieving bed rest has been the problem of parents or hospital personnel, with no recorded standards of care available as a guide, in terms of adequate educational and emotional opportunities. The child, by virtue of being a child, must be given a suitable environment with satisfactory experiences, if he is to grow normally and without psychological trauma.

The desired bed rest is not possible unless suitable creative occupations are provided that will limit the physical activity and give emotional and intellectual satisfaction. In the experience of the last seven years, the occupations shown in figure 2 have been found most satisfactory in supplying the normal needs of the child and at the same time in limiting his physical activity. Unless a medium for self-expression is offered the child, he will resort to antics that are physically exhausting and are the antithesis of bed rest.

The mere listing of possible occupations can be of little value unless the innumerable variations and modi-

SAMPLE SCHEDULE FOR JOHN SMITH, AGED 10

MORNING

7:00: Temperature, pulse and respiration taken.

7:10: Morning toilet performed by child under supervision of nurse. Dressed in T-shirt, slacks and socks. Medals or decorations desired by John pinned on to his satisfaction.

7:30: Breakfast.

7:50: Bathroom privileges.

8:00: Carried to schoolroom and made comfortable in chaise longue. His school box is placed near enough for him to reach his equipment. He will have six or seven companions of similar age for the school session. The teacher lives out and consequently brings a fresh, stimulating aura with her morning greeting.

9:30: Carried back to bed for rest hour, bathroom privileges, glass of water. A pillow is placed at soles of his feet and he is covered with a blanket. Windows are opened; the shades drawn. Ten minutes of autosuggestion is given each rest hour. The nurse describes in a soothing voice a limp body, the engine turned off, no power, a cat sleeping by the fire and purring, floating on a cloud, a rag doll. Johnny's arm or leg will flop back on bed when picked up by nurse for testing. He will take a great pride in being limp, if nurse using technic is a good saleswoman.

10:30: Bathroom privileges and glass of water. Ceramics class in recreation room with companions of age group.

11:30: Carried back to ward. Preparation for dinner.

11:40: Dinner served on tray in bed. Table designed to sit on the bed, giving elevation for comfortable management of food.

12:00: Occupation of choice (usually loud conversation with roommate, comparing of morning experiences or possessions). Shouting and squabbling goes on without interference during this half hour.

AFTERNOON

12:30: Rest hour with same procedure as in a.m.

1:30: Bathroom privileges, glass of water, tidying of person preparatory to returning to school.

1:40: School session. Curriculum of school district followed for whatever grade level child is ready to assimilate.

3:00: Return to ward, changing from clothes to pajamas, glass of water, fruit, bathroom.

3:15: Quiet play, elective occupation, such as writing letter home, game, puzzle, book, mechano sets. Talking is discouraged during this period, also sharing of activities.

4:15: Temperature, pulse and respiration recorded.

4:30: Preparation for supper.

4:45: Supper.

5:15: Carried to tub for bath. (This may have taken place in afterschool period.) Bathroom.

EVENING

6:00: Religious instruction on Thursday (something different other evenings in this period, such as bingo or story hour).

7:00: Reading or quiet play. Temperature, pulse and respiration recorded. Glass of milk, bathroom privilege.

7:30: Prayers and songs.

8:00: Lights out.

NIGHT

1-3:00: Sleeping pulse taken by night nurse and recorded.

fications of all are considered by the individual selling them to children. Each child is a different personality and must be treated according to his own drives and interests. The most important factor in supplying the child's normal needs is genuine love and respect for him. Out of this will grow a working friendship through which he may be led into a relaxed and busy life and the necessary limitation of physical effort.

Environment is an accepted component of normal living; so is it for the ill child. Therefore, pleasant surroundings, such as window arrangements permitting wide views, colorful pictures for the walls, and a cheerful, rather cozy atmosphere, are important for the hospitalized child. These environmental influences should have a functional design, allowing as much participation as possible for the inhabitant of the room in the choice of picture, position of bird feeder, choice of neighbor for the next bed, and the like.

It is not normal or desirable to keep a child in the same bed in the same room 24 hours a day. We have learned that a sense of action and movement can be given by holding different activities in different rooms and by transporting the patient to these rooms. A chaise longue with a hump under the knees, a back permitting a slightly reclining position, arm rests equipped with a board that serves as a desk, these provide a comfortable simulated bed position.

In our experience, this position is more restful than that of the flat bed or the gatch frame bed, which never seems to fit in the right places to give adequate support. Patients at bed rest are carried to these chairs, while patients who have progressed to the point of being up three hours or more walk to the various rooms where school desks or work tables with appropriately sized chairs are provided.

Perhaps the concrete way to demonstrate how a practical program can be arranged, which will include all of the factors discussed this far, is to give a sample day's schedule as shown on this page. Suppose the patient at bed rest is John Smith, aged 10, with clinical evidence of rheumatic activity.

LABORATORY PROCEDURES

The laboratory procedures necessary to determine the stage of the disease or the absence of rheumatic activity are performed for each child as casually and inconspicuously as possible. For instance, a throat culture is "after school," a venous puncture "before breakfast."

The following laboratory procedures are routine in our program:

1. Electrocardiograms, stethograms, chest films, and fluoroscopy: At admission and discharge and on order of attending physician.

2. Sedimentation rates: Every week while elevated; every two weeks when normal. Extended to every three weeks after sulfa prophylaxis is established.

3. Complete blood count: At least every two weeks during rheumatic activity; more often as indicated. WBC and Differential every week for five weeks or more during establishment of sulfa régime, then back to complete blood count every three weeks.

4. Throat cultures: On admission and every three weeks during September to April; then every four weeks.

5. Urinalysis: Every three weeks; more often when sulfa is started. Every week during establishment of sulfamerazine prophylaxis.

6. Sulfa levels: Every week for the first five weeks of regime or until

satisfactory levels are obtained; then every three weeks.

The psychological consultation for each child is an out-of-school session to "play games with the doctor." The dental care given by the attending dentists is regarded as another trip or outing. This does not mean we are claiming the dentist is the most welcome guest but rather a philosophical acceptance of something that goes into growing up.

The interpretation of any program or technic gives the degree of effectiveness. The personnel required to establish the atmosphere and guidance of these patients must have an understanding of the normal development and behavior of the child. In-service training by a child psychologist is practical, but is slow and sometimes expensive for the numbers enrolled. There is a need for training, either in short intensive practical courses given by child behavior clinics serving a wide area or through the incorporation of this training into nursing education.

CHILDREN EXPECT ATTENTION

Children are conscious of all that goes on about them and expect attention and interest from each person contacted. Consequently, all employes must have an appreciation of the overall principles adopted for their care. This can be accomplished through staff meetings. An added dividend accrued from this practice is a concerted effort to maintain positive policies.

The staff we have found adequate to implement the foregoing program consists of one nursing supervisor, three nurses, and three aides. One schoolteacher and one recreational director are responsible for coordinating the school curriculum and occupational programs, as well as supervising the seven or eight volunteers assisting in the program.

The variety of interests the volunteers bring to our children includes nature study, Junior Audubon, music, crafts, carpentry and religious education, both Protestant and Catholic. The volunteer is a most valuable hospital asset. The communities we serve have provided us with faithful, skillful and cooperative volunteers who have added immeasurably to our children's well-being and happiness.

The Children's Heart Unit of the Victoria Foundation is a nonprofit voluntary hospital, licensed in the state of New Jersey. A medical board is responsible for developing the most efficacious treatment known and available for children with rheumatic fever. The services the program offers include diagnostic examinations, prophylactic treatment, and follow-up medical supervision for children 3 to 16 years of age through the outpatient clinic.

It is significant, as well as commendable, that the funds which make this rheumatic fever program possible are given by a family that recognized the problems of the disease through its own experience.

When the public realizes that early and adequate care for the rheumatic fever patient can prevent rheumatic heart disease, it is my belief that funds will be raised to maintain the beds required for the cases found in any community. Under the foregoing program, which provides all the essential services except surgical facilities, the cost per patient day was $8.42 in 1948.

If Surgeons Behave Like Human Beings

IN AN interesting article "More Human Attitudes in Surgical Practice," published in the May 1949 issue of the *Archives of Surgery*, Harry B. Zimmerman, M.D., president of the Western Surgical Association, makes a plea to the surgeon to develop the highest type of surgical practice for the good of the community, as well as for the development of the highest types of surgical technics.

The author's plea is motivated, to some extent, by the recent publication in lay magazines of articles criticizing surgeons for doing unnecessary and ill-advised operations. He points out that physicians in their own medical journals have pleaded guilty to this accusation and urges a correction of this situation. He goes on to say that ill-advised or unnecessary operations are performed on the following bases: (1) dishonesty; (2) ignorance of other than therapeutic procedures; (3) too great a zeal for technical achievement.

The first can be overcome by (a) selecting applicants for admission to medical schools more carefully; (b) giving the students a more cultural and humane basis on which to build a medical career; (c) a continuing indoctrination with proper ethical values. The author in elaborating point (a) feels that the premedical course should be eliminated and in its place there should be a general education of from three to four years in a liberal arts college. All medical men should realize that philosophy and the humanities are really the basis upon which a physician must carry out his scientific knowledge. The surgeon, specifically, must be trained to recognize that his patient is a human being, and what happens on the operating table is going to affect that patient and the patient's environment for all time.

When the student passes through medical school and becomes an intern, he has reached one of the most important phases of his education. Much must be made of this impressionable part of his medical life and he must be educated properly by the attending physicians on the staff of his hospital.

It is important that surgeons impress their students with the idea that teamwork is necessary in the treatment of a patient and that while they are being trained as surgeons, it is necessary to recognize other forms of therapy as an aid in this treatment. The author goes farther in stating that cooperation among the physician, the surgeon, and the psychiatrist is not enough, and he feels that more active collaboration is necessary.

The author states that the membership of the Western Surgical Association is divided into two groups, those who chose an academic career, and those engaged in private practice, and while the function of the teaching surgeon is to teach, the surgeon who engages in private practice, in a broader sense, is a teacher, too. He must educate the younger generation for proper service to the community by fostering better surgery, better hospital facilities, and better surgical personnel, and, finally, the realization that the surgeon must be a humane and social-minded individual. — IRVING GOTTSEGEN, *Montefiore Hospital, Country Sanatorium, Bedford Hills, N.Y.*

The RECOVERY ROOM

has much to recommend it

N. WILLIAM WAWRO, M.D.
Hartford Hospital
Hartford, Conn.

WHEN the new Hartford Hospital, Hartford, Conn., was still on the architect's drafting board, space for a recovery room was allocated in the operating room suite. We were fortunate enough to obtain the services of top-notch hospital engineers, consultants and architects. An $8,000,000 investment could not be planned lightly or incompletely.

We also were singularly fortunate in having on our full-time staff one of the leading anesthetists in this country, Dr. Ralph Tovell, who subsequently served as consultant in anesthesia to the surgeon general for the European theater and is now with us again.

Thus the best ideas in current civil practice were blended with observations made in military installations while we were planning the recovery room, and the result, after five tedious years of planning, was a specially equipped and staffed unit in the operating room suite, adjacent to and available to all necessary auxiliary services.

The recovery room is a unique idea by present hospital standards. As few institutions have this scheme, we are swamped with visitors from South America, Europe and from our own land who, when they plan a tour, want to see what the recovery room is.

All operative cases that are taken care of on this floor flow into this recovery room suite. Each bed has its own supply of oxygen as well as a suction unit built into the adjacent wall. The oxygen and suction unit is always available at the flick of a wrist. This unit is foolproof. It is fixed in position and convenient, and it eliminates the hurry call for heavy cumbersome oxygen tanks or portable suction equipment.

The blood bank is on the floor beneath this unit. An automatic conveyor system with all hospital facilities connecting to this room permits special drugs or fluids to be dispatched more rapidly than personnel can hope to bring them. This is simply a converter unit built through the 13 floors of the hospital on two separate levels, and it is constantly revolving and ascending. It is connected with every floor, with every nursing station, every laboratory and the pharmacy. If anything is needed, one calls the department that he wishes to contact and sets the lever, and a plastic box, measuring approximately 2 feet square, immediately goes on its way, arriving at the destination within a matter of minutes, whereas in the average hospital the size of ours it would take 10 to 15 minutes at best.

We also have a corps of specially trained lay and nursing personnel assigned to this unit; this is its sole task in the hospital organization. It is not a part-time task with these employes, it is their sole job. They arrive in the morning at 7 and leave at 7 at night. Anesthetists and physicians are in constant attendance and are available for any emergency, inasmuch as the recovery room is on the operating suite floor.

Most important of all, no patient is allowed to return to his room until he is awake, the airway is adequate, and the vital signs, that is, blood pressure, pulse and respiration, are stable.

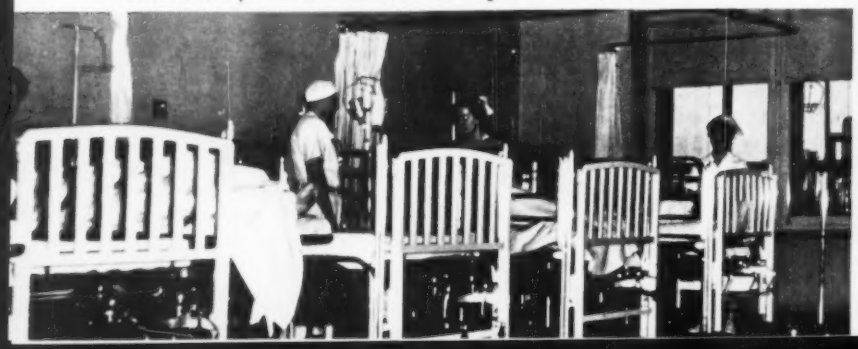
Whatever obvious safety to patients and/or comfort to the physician attends this scheme, let us not lose sight of another major contribution resulting from this idea. We are faced with a major nursing shortage, and to fill this hiatus more auxiliary lay personnel is engaged in hospital work under the supervision of graduate nurses. Often in the average hospital, a postoperative case is brought directly to the room or ward, and a lay attendant or nurse is assigned to observe the patient. Multiply this situation by 20 or 30, which is the average operative load of the active hospital, and one then summarily drains off 20 or 30 nurses or auxiliary workers.

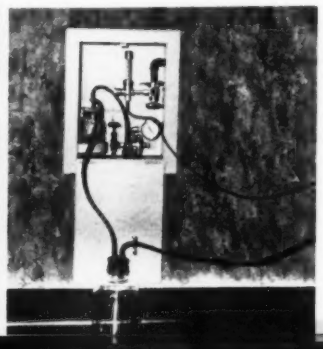
Similarly, the house physicians must cover this widely separated group of patients during the immediate postoperative state. Without a recovery room, at certain times in the day there must be a nursing shortage added to an already present shortage, not to mention the isolation of many acutely ill patients from the limited numbers of house surgeons. We feel that the recovery room aids materially in resolving this problem.

Too, the recovery room has much to recommend it in terms of community service. We had an experience several years ago when we were swamped with hundreds of badly burned patients from the Barnum and Bailey Circus fire. You can well imagine what would have happened in the average hospital with ambulances and private conveyances bringing in hundreds of patients in shock, patients suffering from difficulty in breathing resulting from inhaling smoke and fire, patients actually burned. Such a situation throws a hospital into a turmoil. It is imperative to mobilize the best resources; yet when these patients are spread out, it is impossible to take good care of them. We partly solved this problem by clearing out large wards and assigning these patients to them.

We feel that with a recovery room any disaster can be adequately handled.

Left: Recovery room is in constant use. Right: The built in suction unit.





It takes a doctor to tell you

The Things a Patient Puts Up With!

L. W. JAY, M.D.

THE physician and hospital worker who changes his point of view to that of the patient quickly learns a lot of new things about his own institution that are surprising, and some of them are even staggering.

Some years ago I was a hospital patient for a medical condition and wrote about the things I saw and experienced from that worm-in-the-apple point of view.* Recently I have been a patient again, for major surgery this time, and once more record some observations. My background includes several years of hospital planning and construction, also long periods of administration. These observations are submitted with the hope that they may aid others to detect unsatisfactory details in their own organizations.

ALL ONE COULD ASK

The doctors were all that one could ask, competent, carefully selected, always alert to the needs of their patients and I have every reason to believe that they gave me the most distinguished consideration. On several occasions when consultation was needed a highly qualified specialist was there almost immediately with whatever was needed in the way of equipment and technical help. Nothing that may be said is intended to reflect unfavorably on them in any way.

Much has been said in recent years concerning the changed attitude of nurses toward their work. I had plenty of opportunity to observe them and their conduct, as I had three special nurses for three weeks, and I was probably a most difficult and irritating patient, as physicians are likely to be. Without exception they showed complete devotion to the welfare of their patient and neglected no task, however menial, that might add to his comfort and well-being. It is a pleasure to invite attention to the excellence of both doctors and nurses.

The hospital was large and completely departmentalized, occupying several buildings. The one I was in was four stories in height, with reinforced concrete frame and hollow-tile walls, built about five years ago. Acoustic tiles have been applied to the ceilings of some rooms and corridors, but omitted from many of the spaces where most noise originates, such as utility rooms and bathrooms. Any metallic sound, such as that produced by dropping the lid of a stainless-metal dressing container, reverberates through the building, coming and going for several seconds.

The rooms were heated by wall radiators with heavy metal covers. The heat was turned on continuously and the temperature was controlled by opening or closing various windows and doors. As the spring advanced and days became warmer I suggested that the heat be turned off as it was no longer needed. The orderly opened the small access flap in the radiator cover, but reported that he could find no valve inside. While trying to reach as far as possible the heavy metal cover became detached and fell with a resounding clang. It revealed that the valve was 20 inches away, on the other side of the radiator space, far out of reach from the access opening.

The loud noise brought several nurses and orderlies on the run. Five different ones tried to replace the radiator cover, some by bull strength and some by careful adjustment, but none could make it stay in place. So it was decided to brace it with a chair until the engineer arrived which, I was assured, would be only a few minutes. Four days later he came. He told me that all the radiators in the building had the same jackass rig. To obtain a small saving the contract had been divided into one for installing the radiators and one for providing and installing the radiator covers. Apparently nobody thought to correlate the type of radiator with the type of cover. As the valves could not be reached for turning the heat on or off, the easiest solution was to leave the heat always on and to open the windows when it became too warm.

The cost of fuel wasted each month by this prodigal method must be several times the amount saved in the contract. Small economies in construction thus may lead to long-range extravagance and seem heart breaking to the administrator who is trying to make both ends meet. I discussed this matter with another hospital administrator who told me that in some of his buildings there were no valves to the radiators in the individual rooms. The heat was either on or off in the entire structure and changes in temperature for the patients were made by opening or closing doors or windows.

"KEEP CLOSED"—BUT IT ISN'T

A Midwest hospital burned with considerable loss of life about the time I was beginning to improve, so I scouted this one for fire protection. Hoses and extinguishers were adequate in number, well placed and carefully maintained. The building was as fireproof as possible and there were no flammable hangings. At each end of the building on each floor was a fire alarm box, hand-activated, not automatic. High-pressure standpipes were being installed with pumper connections outside and outlets at each end of each floor. Elevator shafts were fully enclosed and at each end of the building was an enclosed stairway with each door marked in large red letters, "Fire Door. Keep Closed."

But all the doors to one of the fire stairs were kept open with wedges, day and night. In the basement, near the foot of the stairway, were storerooms which contained tanks of gas

*Jay, L. W.: It Could Happen to You. Mod. Hosp., 66:43 (April) 1946.

and other combustible materials. A fire originating in the stage area might quickly fill the floors above with smoke and hot gases, causing the type of panic which is often far more deadly than the fire. Open stair wells have been a fruitful cause of loss of life in many hospital fires. This emphasizes the fact that the most elaborate structural provisions may be rendered useless by lack of administrative supervision. Reappraisal of methods of fire protection must be constant, because much new information is being derived from studies of recent disastrous fires.

Wheel chairs, wheel stretchers, food carts, laundry carts, linen hampers and backs of chairs all rub the walls and door frames of rooms and corridors at different heights, causing a maze of streaks and abrasions. Why wouldn't it be possible for the makers of this sort of equipment to get together and redesign some of the articles, so that a rubbing-strake, perhaps 6 to 8 inches wide on the walls, would protect them from injury by the more commonly used types of furniture and equipment?

NO KNOBS—NO SCREWS

Overbed tables of the conventional type are raised and lowered by turning a handle which terminates in a knob. A large percentage of the tables that I saw had some of these parts missing. Some had lost one or both handles completely while others had lost the small knobs, which made it very difficult to adjust them. These small parts are secured by screws, which seem to come loose within a short time. There must be some simple method of fixing them in place, which would add greatly to the useful life of the table.

The center section of the overbed tables can be raised on a ratchet so as to hold a book, a mirror or a magazine. On the bottom edge is a metal strip, held by two screws, which can be raised so as to form a ledge for supporting the mirror, book or other object. But the screws sometimes come loose and are lost, so that the strip hangs by one side or is detached entirely, which interferes seriously with the use of the table. I suggest to manufacturers that they find some method of anchoring these small but important screws more securely.

The gadgets for locking the wheels of the bed so that they do not move seem to be very fragile. Mine was a new and very intricate bed and people came in frequently to admire its versatility. From day to day small pieces of the wheel-locking device were found on the floor. As nobody seemed to know how to replace them, they were quickly lost. If this is a valuable attribute in a bed, it would seem worth while to make it permanent.

The mattress on my bed was 12 inches shorter than the spring. Sometimes the mattress was at the head of the bed and then my feet hung down in the hollow while all the bed clothes, moved by some irresistible gravitation, inched gradually into that depression. When the mattress was at the foot of the bed the pillows disappeared into that seemingly bottomless abyss beyond the mattress. The blankets were hard and shrunken, coming just breast high, so it was found advisable to wear a sweater at all times.

Another minor inconvenience was the absence of hooks in the bathroom. What to do with the bath robe, pajamas and towels became a problem of real magnitude to the disordered imagination of a sick person. I strongly recommend at least two hooks on the door of each bathroom, as a good-will item.

One experience made me realize why general practitioners have such an enduring place in the public esteem. One morning I woke with a bubble in my ear, so I could not hear well. The eye-and-ear department was called, but all the doctors there were operating and I was told that they would leave immediately after the operations were finished. One department after another was called, but in all that large institution not one physician could be found who was willing to undertake such a delicate operation as washing out an ear. Each was a specialist in something else. So mine was the choice of going out into the city to find a doctor, or else waiting until noon of the next day when an appointment could be arranged.

The wakeful patient could know the time in the early morning without a watch. At 4 a.m. the unmuffled scooters began their uproar. About 5 the huge motor-trailer combines started to arrive and spent many noisy minutes maneuvering into position to discharge their contents. At 6 the trash collector began his rounds, beating the metal containers like tom-toms and then throwing them down to bounce on the concrete. But by that time it was the hour to prepare for the bath. Often, after wooing sleep in vain most of the night and falling asleep in the early dawn, it was difficult to awake in a calm mood at 6 o'clock to be bathed, even though I understood the reasons for it.

Special note for dietitians: If you enjoy fun, try this, it is sure fire. Take a very small orange and cut it in two. Give it to the bedfast patient with a broad, thick spoon, first arranging the overbed table so that it fits tightly under his chin. But stand well back when the juice begins to fly as he struggles to get something nutritious from the orange. Why must spinach and other vegetables served in a hospital always be bitter? Why must hospital soups always be so thick and flavorless? These questions put to the dietitians produced shocked surprise but no other change.

A SALUTARY EXPERIENCE

I believe it is a good thing for the physician to be reminded from time to time of the cumulative effect of repeated minor discomforts on the temper of the patients. For instance, the first few jabs of the intravenous needle can be laughed off, but multiple repetitions in several parts of the body can be blown up by a sick imagination to a major grievance. Some of my best-loved confreres lost stature in my esteem because of their bungling attempts to find a vein with a needle, while youngsters of little other ability won my affection by reason of their deftness with the needle.

Other minor discomforts linger as unpleasant memories, even though I understand the reasons for them. A lay patient, knowing nothing of the difficulties and technics which lie behind the procedures, can easily be even more unfavorably impressed. While the patient may conceal his reactions from the physician, they are widely discussed with his family and friends and they become a part of the reputation of the physician and the hospital.

Among those discomforts were the shock of the cold stethoscope; depilation by jerking off adhesive plaster; too lusty traction and jerking when removing tension sutures; the moment of terror on awakening in an oxygen tent after a period of delirium. These might be ameliorated by a little more thoughtfulness, with benefit to the good will of the hospital and the physician.

The trustees took a hand in designing Hahnemann's

BASSINET STAND

ERNA M. KUHN, R.N.
Superintendent
Worcester Hahnemann Hospital
Worcester, Mass.

AT A recent meeting of the Massachusetts Medical Society we exhibited some new bassinet stands that were manufactured for us in Worcester. Their simplicity and efficiency appeared to have considerable appeal.

Our board of directors had a large share in designing the unit and I never saw a group of men so baby conscious and nursery conscious as the trustees were during the remodeling period.

The bassinet frame was made of seamless, stainless metal in a factory owned by one of the members of our board. He presented the stands to the hospital as a gift. A lucite panel is so attached that when the bassinets are arranged in the nursery the panel serves as a cubicle wall protecting one infant from another. This was the idea of another member of the board whose factory devised a way of fastening these to the frame. A swinging tray was also manufactured locally. It is easily removed and cleaned, and contains thermometer, oil, alcohol and other supplies. The removable shelf holds a full day's supply of clothing and a small stainless metal basin.

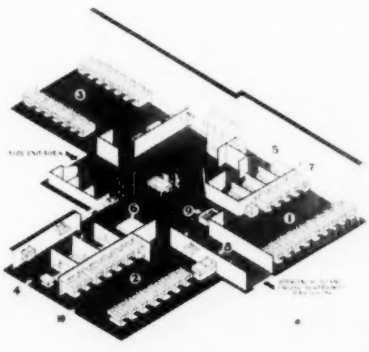
The infants are cared for from the end of the bassinet, and the nurses find the bassinet easy to keep clean as it washes like a dish. Bed clothing is easier to tuck in than is the case with the usual type of bassinet, and its transparency makes the babies more visible. The bassinet linings are disposable, which is a saving of time.

Our present nursery is made up of three individual nurseries of 15 bassinets each; one suspect with three cubicles, and one premature nursery with four cubicles. There is no isolation unit. Infants requiring isolation are removed to our pediatric unit. We operate on a rotating system, *i.e.* when a nursery is filled no babies may be admitted to it until it is completely emptied, cleaned and rested. This makes possible a thorough cleansing that is a serious problem in the average nursery.

In spite of all these safeguards we have provided, we still feel that infant protection is only as good as the technic of the nurses, but we find that by using this nursery, and the proper technic, seldom do we have a baby in the suspect unit and almost never do we have to isolate an infant.

Above: The lucite panel serves as a cubicle wall to protect the babies. Right: Layout of the Hahnemann Hospital nursery.

FEATURES STRESSED IN AN IDEAL MODERN NURSERY FOR THE NEW BORN



ISOMETRIC DRAWING OF THE HAHNEMANN HOSPITAL NURSERY

What the patients think about hospital clinics

IN HIS "A History of Medicine," Dr. Douglas Guthrie says that, so far as is known, the first clinics were held in 350 B.C. by Hippocrates on the Island of Cos where a gigantic tree, in the center of the town, is even now pointed out as the place where he taught his students. Doctors and nurses are still taught in clinics, many of which in their many-storied, finely equipped buildings are a far cry from the tree of Hippocrates. At the moment, however, we are concerned not so much with the large diagnostic clinics for private patients as with the small hospital clinics attended by the medically indigent, persons who cannot afford a private doctor or doctors. Even the so-called "small" hospital clinics, in their efforts to prevent and to cure disease, do an untold amount of good, and, through no fault of the sponsoring institution, leave undone much that should be done, especially in the way of preventive medicine. In many directions, and by diverse institutions, giant strides have been made; in others, the pace forward has been of the tortoise variety.

RULES FOR DISPENSARIES

Certainly it is many years since the Associated Outpatient Clinics of New York set up the following rules for a properly managed dispensary:

1. The unification of ward and outpatient staff and services.
2. The limitation of patients accepted for care.
3. Adequate records of the medical work, the attendance, income and expenses.
4. Adequate pathological and x-ray laboratory services.
5. Proper assistance to the physician by nonphysician personnel.

Twenty-five years ago (1923) Michael Davis wrote: "Good reception is an index of competence of management throughout the clinic" and added: ". . . These considerations have become pertinent since clinics ceased to measure their accomplishment by numbers reached, and attempted to improve the quality of their service by limiting the patients to a number the attending physicians could treat adequately in the clinic hour." (Was Dr. Davis too optimistic?)

The well-known authority on clinic practice, Dr. Samuel Bradbury, who has had a long and varied experience, lists "pressure for admission of new patients as one of the greatest difficulties in the appointment system." This is particularly true of the voluntary neighborhood and church hospital type of clinic we have specially in mind.

How many hospitals, even today, are unable to comply with these eminently logical rules! Recently a New York magazine published an article headed "The Poor Stand in Line," which began this way:

"Did you ever pass a downtown cafeteria during the lunch or dinner hour? The long lines form by magic; patiently and quietly those who have to count their pennies edge slowly forward to gain new sustenance according to their means. Or again, go to the clinic in a big hospital and see the sick and the maimed wait hour after hour to get a treatment given often with scant courtesy." We hope the "scant courtesy" is the exception and not the rule.

Clinic patients do not always actually stand although we have all seen some pretty long standing lines; they may sit for hours in surroundings that by no stretch of imagination can be called attractive—may not even be comfortable. One Philadelphia administrator who himself runs a large, airy and well managed clinic has this to say:

"The location of the clinic, the appearance of the waiting rooms, as well as the private offices of the doctors, should be friendly, cheerful and clean. It is bad enough for most patients to have to seek free medical care, but they should not be further humiliated by the kind of atmosphere to which they are subjected in order to get this care."

To learn something of how clinic patients themselves react to present-day procedures, identical questionnaires were given to patients in eight hospitals in different parts of the country—three in the East, two in the Middle West, and three in the South.

In the hospital where the largest number of questionnaires (more than 1100) was returned:

45% said they waited from one to five hours.

69% preferred the clinic to private doctors and some gave excellent reasons for their preference.

26% preferred private doctors.

5% gave no answer.

8½% waited "too long" or wanted more doctors and nurses to shorten the waiting period.

All but 18 patients said they saw a doctor at every visit; 28 did not answer the question.

161 patients wrote notes of appreciation and commendation of the services received. They thought "everything was fine," "could not be better," and so on.

In another Eastern Hospital:

28% waited from three to four hours and several asked that the service be speeded up—thought the wait was too long and mentioned particular clinics.

14% said if they had money they would go to a private doctor; two added that they would do this in order to leave their places in the clinic for the poor.

All but one patient saw a doctor on every visit.

In a larger hospital:

54½% waited one to four hours but only 15 patients commented on the time.

One person said "was no longer than in a doctor's private office." Another said: "But you expect to wait in a clinic" and she came from a distance.

9½% would go to a private doctor if they could—two again in order to leave the clinic to others.

Ten patients wrote quite long letters of appreciation. "Better staff would be impossible," wrote one.

In a hospital farther West:

36% waited less than one hour.

44% one hour.

12% one and one-half hours.

8% waited two hours.

No one complained of the waiting time but 20 per cent when asked for sugges-

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Mater Misericordiae
Merion, Pa.

tions for improvement of service, mentioned a shorter waiting period.

96% said if they were in a position to pay for the service, and could still receive it at the clinic, they would prefer the clinic to going to a private doctor's office.

100% answered the question, "Did you feel welcome and at home, or unwelcome and lonely?", that they felt at home and welcome, which speaks volumes for the personnel as the physical setup of the clinic is not at all what the management would like. In fact, the administrator spoke of it as "dilapidated," and yet the patients were happy.

72% could not make any suggestion for improvement.

92% said they were benefited.

In a large Southern hospital:

40% waited from one to six hours.

18% "waited too long" or "a long time."

34% did not see a doctor every time.

20% would prefer private doctor—two so as not to deprive a poor person of a place in the clinic.

All thought the doctors were efficient and gave a thorough examination.

In another large Southern hospital:

40% waited from one to 3½ hours.

60% waited less than half an hour.

25% preferred private doctor—two to give clinic places to poor.

Three asked for a private "classroom for mothers"; another wanted a playroom for children.

In a small Southern hospital the question as to waiting time was omitted but 15 per cent wanted more help and more doctors.

33% preferred private doctors.

A number thought they were benefited by contact with other patients.

In a large hospital in the Middle West:

50% waited from two to four hours.

20% asked for more doctors and nurses.

20% would go to a private doctor if they could afford it.

10% felt lonely.

15% did not see a doctor on every visit.

All thought the doctors courteous and helpful.

Two incidents came to my attention at practically the same time, and probably that is the reason the contrast struck me so forcibly. The first was told to me by a board member of the hospital concerned. Late one autumn afternoon, a medical social worker found a Negro timidly knocking at the back door of a Texas hospital. The man was described as about 65 years of age, of unusually large physique with a massive well-shaped head covered with crinkly white hair. A rich deep voice was intensified by a respiratory infection. Though it was raining heavily, the worker had difficulty in getting the man inside the door. To urgent questioning he replied that he would like a little cough medicine for his cold. The worker realized there was much more than a cold to be dealt with, that the man was sick and should be hospitalized. He finally agreed to stay provided she would first listen to his story, which was, briefly, that he was a life prisoner for murder and was on three months' parole because of his cough. He was given the last available bed in this small hospital. At the end of three months, his condition was worse. An appeal to the pardon board and another to the governor obtained an additional three months, after which the patient was returned to custody and died shortly thereafter.

In February 1947, the *Reader's Digest* published the following and credited it to Michael Wright in *Better Homes and Gardens:*

"This is how it is in Britain. The doctor got back to his office just at 2 o'clock. 'How many?' he said to his nurse.

"'Forty.'

"Casually, he put on his white jacket and poked his head into the waiting room where the 40 patients sat. 'Will those of you troubled with headache please stand,' he said.

"Six stood. The doctor took identical printed prescriptions out of his desk and handed one to each of the six and dismissed them.

"Then he said, 'Will those of you troubled with a cough please stand.' Another group got up, and again he handed them printed prescriptions and dismissed them.

"The others he took one by one into his private office for a few minutes. Two hours later the office was empty, the 40 patients gone. This was an average of three minutes to a patient."

Geographically, the two places were thousands of miles apart, but spiritually and medically the distance between them was much greater.

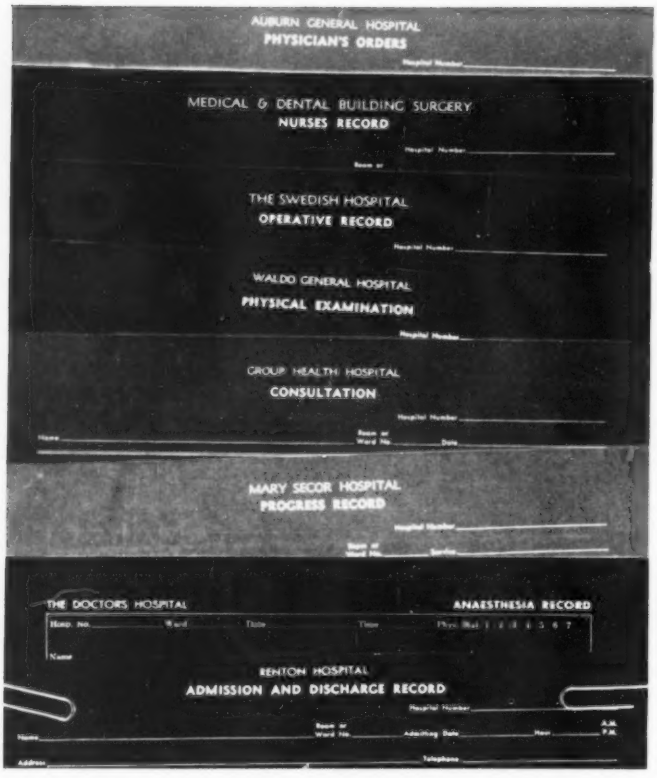
After analyzing the questionnaires, I am convinced that while it is desirable to have adequately spaced and bright accommodations for dispensary patients, the character of the personnel handling patients is of vastly greater importance. The bulk of the criticisms in the questionnaires had to do with the long waiting time and the need of more doctors, more help, more nurses in order to shorten the time. Repeatedly these words appear in answer to the question: "What suggestions do you have for the improvement of our service?"

THEY HAD OTHER SUGGESTIONS

Other suggestions were: "better light — brighter paint — more courtesy — better ventilation—every day we see a different doctor — have same doctor each time—explain more to patients—send written diagnosis to home—have people who understand different languages—something to read while waiting—more chairs and benches for long waits—have evening clinics with higher charges to save waiting time — take children first—less red tape—doctors should be on time—friendlier attitude —more individual attention."

Only in one institution was there real criticism of the work of the doctors, and these seemed to be unsupervised interns. Over and over again the patients stated that they felt they had been benefited, that they preferred the clinic to a private doctor's office because of the kindness and interest of the doctors and nurses.

Too many of our hospital clinics are today handicapped by lack of space, equipment and personnel, in one word, funds, but these are remediable and the future will see them gradually eliminated by help from one source or another. In the meantime, while we all admit room for improvement, we must admit, too, that the clinics are rendering much and very real service to those of whom the Great Physician has said: "Inasmuch as you have done it to one of these My least brethren, you have done it unto Me."



THE FIRST STEP

Toward Standardization Of Hospital Record Forms

HELEN E. MYERS
President, Seattle and Vicinity Chapter
American Association of Medical Record Librarians

STANDARDIZATION of forms for the clinical records of all hospitals in a given area is basically a very practical idea. The adoption of such forms from the standpoints of both increased convenience and decreased cost would be a definite contribution to efficient hospital management. However, the difficulties involved in bringing this idea to realization have made it a problem which has been ignored by those very people in the hospital field who have most to gain from its solution, *i.e.* the members of the medical staff, the administrator, and the record librarian.

In September 1947 while discussing the problems of obtaining complete and adequate medical records, the Seattle chapter of the American Association of Medical Record Librarians decided that the clinical chart forms then in use in Seattle hospitals were an actual impediment to them in their work. There were more than 10 hospitals in the Seattle area, and each one had totally different clinical chart forms. In the event that a physician belonged to the medical staff of more than one hospital, as the majority of Seattle physicians do, it was necessary for him to become familiar with several, sometimes six or eight, different hospital charts, as well as with the various requirements of each record department. It was somewhat confusing, to say the least, and as a result the medical records were not adequately completed.

The Seattle Medical Record Librarians decided to attempt a solution to this problem. A committee was appointed to investigate the feasibility of standardizing the forms, and the committee enlisted the aid of the representative of an organization which has had much experience in designing and printing hospital chart forms. The chairman of the record committee of one of the larger hospitals submitted a letter to the Executive Council of the Hospitals of Seattle, outlining the advantages of standard record forms, and requesting the support of the council in the project. Their approval was granted. With this encouragement, the printer's representative attended meetings of the various medical specialty groups, interviewed hospital administrators, and heads of the record committees of the various medical staffs, and obtained general approval of the venture.

The standardization committee of record librarians obtained sample copies of charts from each hospital in the Seattle area, and analyzed those chart forms which were similar, *i.e.* nurses' records, physicians' orders, and graphic charts. We found that in all the different types of a particular form, for example the nurses' records, the essential entries were the same, but the differences lay in the amount of space allotted each column, the wording of headings, color of ink used, placement on the page, and so on. The differences were amazingly trivial, hardly important enough to warrant an entirely different plate at the printers for each form for every hospital.

At this point, our printing adviser took over. He made it clear that standardization of forms would be largely a matter of give and take, that compromises would have to be made, and that each hospital would perhaps have to give up or change slightly some of the features in each of its record forms. He then redesigned new chart forms, taking the best features from all the types of forms we had compiled, and presented these sample forms to the record librarians for suggestions and criticisms. The samples were then presented to the department heads concerned in each hospital. Each form had to be drawn and redrawn from four to six times before the changes were all incorporated and the final drawing was approved. The choice of colors for each record was left to our printing adviser, who endeavored to retain the color for each chart form which was then in use in the majority of Seattle hospitals.

In the standardization of the 10 or 12 record forms which have been completed to date, we have had the cooperation of the hospital administrators, the University of Washington Medical School, and the members of the record committees on the various hospital staffs.

The chart forms which have been standardized are now being used in most Seattle hospitals, and to date more than 35 hospitals in this area have adopted them. The work is progressing on the standardization of the remainder of the chart forms, those special report records such as x-ray reports, pathologist's reports and obstetrical records. However, it may take more time to obtain the support of specialists in these fields.

The advantages of standardization are already benefiting the medical and hospital professions in the Seattle area by reducing the printing costs for the hospital, by providing the convenience of easily identified chart forms for the medical staff, and thereby assisting the medical record librarian in her work of promoting complete and adequate medical records. We feel that the first step has been taken in the direction of achieving the uniform hospital record form for all general hospitals.

PURCHASING IS PART OF THE ADMINISTRATOR'S JOB

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Director
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IN ADDITION to the generally accepted functions of a hospital, namely, care of the patient, teaching, prevention of disease, and research, there is one other that is quite important and on which may hinge the success of these four primary functions. That is the hospital's effort to balance its budget, insofar as possible.

Down through the years, hospitals as charitable insitutions have been expected to lose money, and they have thoroughly lived up to these expectations. It seems to me, however, that there has been a tendency on the part of the administrator to be a little lax in the spending of hospital funds. While hospitals perhaps are not supposed to show an operating profit, there is a very small margin between breaking even on the one hand and not being able to discount the bills on the other.

We cannot expect too much help from the professional staff from the standpoint of finances. The staff members will think you are a good fellow if you accept free patients as teaching cases when sometimes there is doubt as to their value from a teaching standpoint, when you reduce bills if the patient has had some financial difficulties, or when you place a patient in a private or semiprivate room at ward rates. But, when you increase the patients' room rates or extra charges, it is a horse of another color.

It is the administrator's duty to balance the budget as nearly as possible, and if he does not accept this responsibility, or perhaps I should say, if he does not insist on retaining final decision in all major purchases instead of simply becoming a rubber stamp, he is shirking his responsibility.

Some manufacturers and salesmen have been known to say, "What's the use of wasting any time with the hospital administrator; he doesn't know anything about the equipment anyway, and I am going to deal directly with department heads." I think this would be a particularly poor attitude for a representative of any manufacturer or supply house to adopt in approaching a hospital with which he hopes to do business. What a fine state of affairs would prevail were every salesman to come to the hospital and deal directly with each department head, by-passing the administrator.

Back in the early Twenties when I was assistant superintendent of this hospital, a representative of a surgical supply house came to the hospital and went directly to the surgery. The first intimation that he was even in the hospital came when the superintendent was presented with a list of about $2100 worth of surgical instruments which the surgeons had chosen after looking over the salesman's sample case. I was with the superintendent when the salesman presented him with this list, expecting a signed order. I do not know when I have been sorrier for a person than I was for that salesman who received no order except to get out and stay out. It also happened that a few minutes before this salesman appeared the administrator had received the financial statement for the month, and he was not feeling too much like spending $2100 for surgical instruments.

Whether a system of centralized purchasing or one of the many systems of decentralized purchasing is used, the administrator must be aware of the hospital's needs as regards all equipment and supplies. While he may in many cases delegate authority in purchasing, he must reserve the right to question any order and to change or

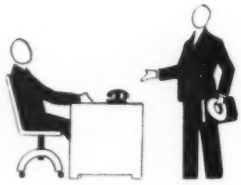
veto an order if he considers it necessary. He must know enough about the purchasing of all types of supplies and equipment and be sufficiently cognizant of prices to justify, if necessary, all purchases and to explain the monthly financial statement.

For example, let us think for a moment of food which makes up a large part of the hospital budget. While the administrator may not visit the market and probably cannot tell you what the menu will be for the next meal, he should be familiar with food costs. At one meeting of our board of trustees, the financial statement for the previous month was presented. It showed a per meal cost, served, of $0.40 for the month of March 1949 as compared with $0.39 for the month of February 1949 and $0.37 for the month of March 1948. And yet we have all been hearing that food costs are coming down. A check-up made previously, in order that this figure might be explained, showed the following comparison in prices of a few much used articles of food between the months of March 1948 and March 1949: beef increased $0.06 per pound, lamb increased $0.09 per pound, pork increased $0.06 per pound, turkey came up $0.13 per pound, eggs increased $0.02 per dozen, ice cream increased $0.12 per gallon. While we believe that we now see an appreciable dropping in prices which may give us a lower food cost, the foregoing items alone amounted to an excess of $1000 per month over the same month of the previous year. An increase of $0.01 per meal in this hospital means an additional outlay of $12,000 per year.

WANTED ASH REMOVER

A few years ago, our engineer came to me with the suggestion that we install an ash remover consisting of a vacuum system which would pull the ashes from the concrete pits in front of the boilers up into a silo-like structure from which such ashes would be dumped into carts. The cost of this equipment was to be approximately $5000.

When I asked him why he wished this equipment he stated that, first, he had trouble keeping firemen because they resented shoveling the ashes from the boilers into large cans and then hauling them up with a block and tackle a distance of about 20 feet to level ground and then dragging these cans out to be picked up by the ash



collector; second, during the winter months it was necessary to have an extra man on the day shift just for the purpose of shoveling these ashes from two boilers, and third, on many occasions we had to pay to have the cinders hauled away—the charge being $2 per load. He proved to me that we could pay for this equipment in savings in a little over two years.

IT HAS PAID FOR ITSELF

Inasmuch as we consider the purchase of a piece of equipment that will pay for itself in five years to be a good investment, I brought the matter to the board of trustees and had no trouble in receiving approval for the expenditure. Since its installation it has paid for itself many times over. The administrator, because he has the final responsibility in purchasing, must be able to justify a purchase just as he must be able to justify the vetoing of an order.

How is the market going—up or down? During the war and for some time thereafter, cotton goods, such as sheets, pillow cases, draw sheets, spreads and also dressings, were continually on the upgrade in price. We, naturally, tried to beat the market by buying before the next rise. When the market leveled off, we stopped buying and decreased our inventory. Now, we keep as small an inventory as possible because the price of textiles has more of a tendency to drop than it has to rise. If the administrator does not watch this market, he may find he has an inventory which he must charge off at a higher price than the market price; for this he lays himself open to criticism.

With whom do we do business? Any letter that comes to the hospital which states that premiums, such as electric clocks, radios and so on, will be given with certain purchases are immediately filed in the wastebasket. Naturally, the price of the premiums is included in the price of the article. The administrator must know from whom goods are purchased. The local merchant should be given preference provided, and only provided, the hospital can buy as well locally as it can elsewhere. When we want something in a hurry, which will occasionally occur, we naturally must procure it locally and we should always have friendly contacts.

How about the accounts receivable and the cash position of the hospital? We have a little more control of the disbursing of funds than we do of the accounts receivable, but these days when most of us see our accounts receivable rising and our cash position falling we must know when to apply the brakes. Perhaps some administrators are so fortunate that they do not need to worry too much about the cash position. I have never been in such happy circumstances, nor do I ever expect to be, nor, in fact, do I think I ever should be.

Several months ago, our surgeons wished us to purchase two new operating tables which cost approximately $1600 each. We needed those tables, in fact, we have needed them for five years, but it is surprising what an excellent grade of surgery can be done on a table that is not the latest de luxe model. We knew the price of such tables was going to increase during the next few months. We also knew that our cash position was not as we would wish it, and we did not want to get into such a position that we could not discount our bills. We knew that certain rates should be increased, operating room rates among them. A cost analysis showed us that we were losing money in our surgeries.

KEEP ONE ANOTHER INFORMED

We have recently ordered the tables as we have also recently increased our operating room rates. Operating room rates are the responsibility of the administration and not of the surgical staff, but it is sometimes politic and produces better personnel relations between professional staff and administrative staff if they keep one another informed about their respective problems.

As I stated at the beginning of this article, it is the administrator's duty to balance the budget as nearly as possible. Unless he has control of all purchasing he cannot accept any responsibility for budget control, and he is not managing his hospital properly.

How to put the control in INVENTORY CONTROL

CHARLES E. DUNCAN
Dayton, Ohio

IT IS not too difficult for a hospital to establish an effective system of inventory control; it is, in fact, quite a simple matter provided, of course, the hospital has some good people to operate it and it takes in all factors for controlling an inventory.

What is inventory control? The very phrase defines itself. It means, concisely, controlling an inventory of supplies, equipment or material by properly regulating purchases and the movements of stock by the use of competent personnel, adequate and complete records, and controlled storage spaces.

It is impossible to purchase goods intelligently, then receive, store, issue and account for them without some form of control. Most businesses learned this years ago but acquiring the knowledge cost them a great deal of money.

The management of almost every business takes good care to safeguard and account for its dollars and cents but for some unexplained reason the supplies, equipment and material used are often allowed to look after themselves. These commodities cost many thousands of dollars but despite that fact they are not adequately protected or accounted for.

An improperly controlled storeroom encourages the lack of responsibility among employes.

Advantages of Inventory Control

The advantages to be found in inventory control are practically without limit; here are some of them:

1. It promotes standardization by showing up the needless varieties of items carried in stock. It is an unnecessary extra expense and a nuisance to stock a variety of the same goods or brands just because one person likes this and someone else likes that when everyone concerned could make use of the same item or brand.

This is the first of two articles on inventory control and purchasing. The second will appear in the December issue of this magazine.

2. It provides a perpetual inventory which is a record of all supplies ordered, received and issued and to whom. It also shows the balance on hand at all times. This can, incidentally, obviate the yearly inventory. Further, it provides a perpetual inventory of dollars and cents spent on supplies.

3. It provides a record of goods ordered in the form of a purchase order. When all incoming supplies are checked and the results are compared with the purchase order and invoice, any discrepancies are immediately shown up.

4. It helps eliminate obsolescence and physical depreciation by showing up what is and what is not being used; there is no guesswork.

5. It provides for adequate protection and proper storage of supplies which eliminate the possibility of storage damage and pilferage from the storeroom.

6. It shows the rate of monthly consumption and the yearly use average.

7. It shows the monthly and yearly cost average.

8. It prevents underbuying which causes an unbalanced stock, often resulting in a serious shortage of much needed supplies. When this happens a definite lowering of the hospital's standards of service takes place, to say nothing of the catastrophe that could happen in an operating room should an item not be available when it is needed in a hurry.

9. It prevents buying in excessive quantities which, unless there is a good reason for it, is a stupid way to tie up good capital. Tieing up capital for long periods of time just to get a purchase discount isn't saving money. The savings — and possibly more—are eaten up by the extra work it makes for everyone concerned, storage costs, depreciation, falling prices (if any), and the inconvenience and embarrassment of not having the money that is tied up.

10. It eliminates order duplication because the inventory records will show what has been ordered.

11. Values as shown by the inventory records provide a basis for financial statements and information for administrative purposes.

12. Inventory records support the various inventory accounts.

13. It will show the expenditures of each ward and department.

14. A history of prices is always readily available without the necessity of going through back invoices or purchase orders.

Fundamentals of Control

An inventory control system that works satisfactorily in one hospital will probably not work in another unless it is revised to conform to conditions found in that particular hospital. In any event, any method used will be based on these nine fundamental principles:

1. Keep inventory investments down to their rightful place in the hospital's bank account.

2. Ascertain which items are no longer being used, items that have become obsolete, and those that have been damaged through improper storage. A decision can then be made as to their disposal.

3. Maintain a dependable day-by-day record of inventory balances by posting every day. It is much easier to keep accurate records by posting up-to-date every day. Shelf balances must be checked from time to time just to make sure.

4. Maintain a perpetual inventory showing minimum, ordering and maximum points, and a complete history of stock purchases and movements. Perhaps it is well to mention here that perpetual inventory records are only used for items regularly carried

in stock. A different filing system is used for all other items.

5. Have a clearly defined system of stores classification, identification and handling.

6. Provide proper storage facilities, such as adequate storage space, well designed shelves and a storeroom so arranged as to afford maximum use.

7. Take proper physical custody measures, such as receiving records and a locked storeroom. Only authorized personnel is allowed in the storeroom. Some industrial plants require their storeroom employes to be bonded but this seems an extreme measure except in a few special cases.

8. Use stores requisitions and common sense to control supply issuance.

9. Keep a complete history of prices paid for merchandise.

Ten Points for Attaining Complete Control

1. Only dependable, competent and qualified personnel should be allowed to work with the inventory.
2. Complete inventory records.
3. The ordering point.
4. Purchasing.
5. Storeroom arrangement.
6. Classification of stores.
7. Identification of stores.
8. Receiving.
9. Storing.
10. Issuing.

All of these points will be considered in detail in the order listed.

Point 1 is self-explanatory so let us go on to:

Inventory Records

Different systems of inventory control require different records but the ones listed here are found in nearly every control system: (1) perpetual inventory records; (2) inventory accounting records (including stores and department summaries, if used, and the various inventory accounts); (3) purchase requisition; (4) stores requisition; (5) credit requisition; (6) custody requisition; (7) receiving records, and (8) purchase order.

I believe that inventory accounting records should be strictly an accounting department function. For that reason they will not be considered in this article.

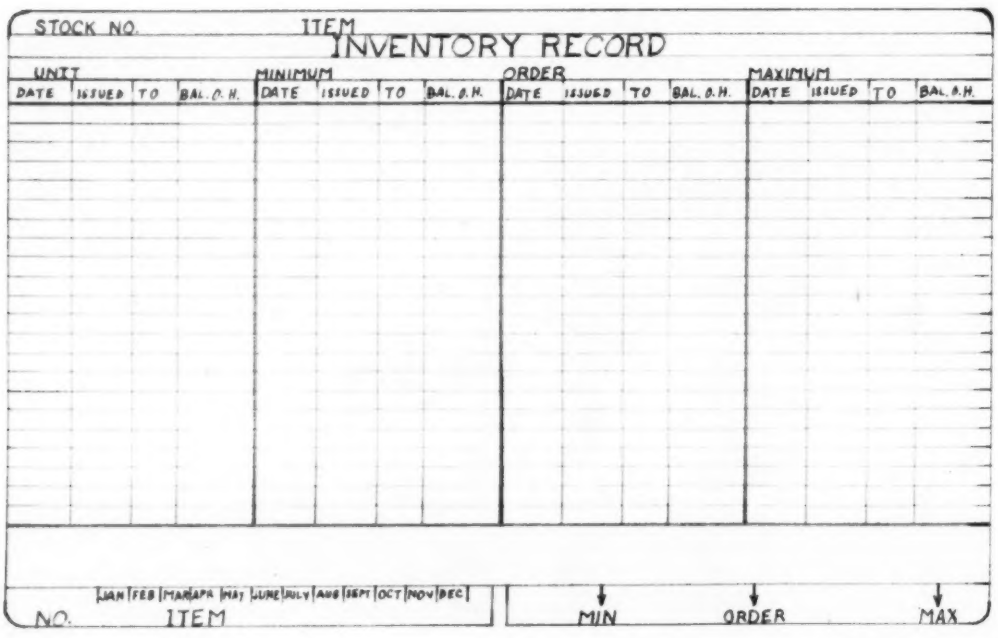
Perpetual inventory records (or stock records if you prefer) are so important to the successful operation of any inventory control system that they cannot be treated lightly. For that reason a set of these records will be discussed in considerable detail. Perpetual inventory records will either make or break any control system almost as much as will the right or wrong type of employes.

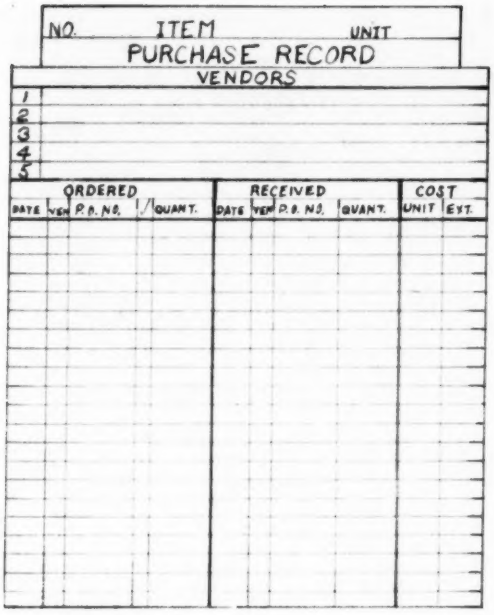
They must be designed with the greatest care and an eye to the future. When perpetual records are once put into operation it is extremely difficult to change them in favor of better ones. The better ones should have been used in the first place. Perpetual records are commonly set up in one of two forms: loose-leaf ledgers or cards. While the ledgers are excellent for inventory accounts they are not satisfactory for perpetual work. The cards housed in a visible index card file are the best for perpetual records.

It is also helpful to keep certain pertinent data on the purchasing department and storeroom or receiving department copies of the purchase order, such as discrepancies found when goods are received, date received, invoice date, and number and price. The data also become a part of the control system. They may seem a waste of time and energy but this information serves as a double check and at times is invaluable.

It must be said now that perpetual inventory records are not inventory control as is sometimes mistakenly thought. They are, however, an integral part of any inventory control system.

The perpetual inventory records to be described in this article consist of three cards: Purchase Record, Inventory Record and Consumption Record. Every article carried on the inventory has its record kept on a set of these




NO. ITEM UNIT
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1
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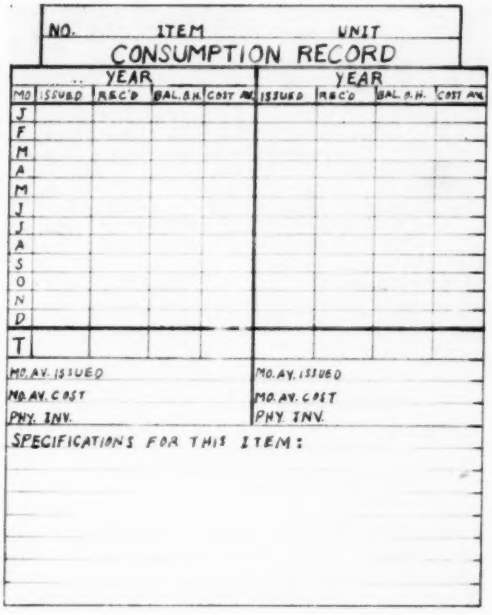
NO. ITEM UNIT
CONSUMPTION RECORD
YEAR
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SPECIFICATIONS FOR THIS ITEM:

three cards. The cards illustrated are intended only as a general outline. They may not work satisfactorily in every circumstance but with some alteration they could be made to do so.

A visible index card file is superior to any other method of filing cards and ledger sheets. It requires less handling, gives the information needed, and the record of any item is instantly visible and available without the necessity of leafing through a ledger or fumbling through a box of cards. This method has one outstanding advantage. When a drawer of cards is pulled out the bottom edge of every inventory record card in the drawer is visible at once. Thus the name of each item, its stock number, the approximate quantity on hand, and whether or not that item has been ordered are all readily apparent without the necessity of looking over every card.

The purchase and consumption record cards are both 4 by 5 inches and the inventory record card is 5 by 8 inches. The inventory card fits in the bottom file pocket and the two small cards fit in the pocket directly above it. These cards can be printed by any printer, preferably on light green or buff index stock. They could be printed on both sides for economy.

The inventory record card is a record of stock issued, stock received, and balances. It has spaces at the top for the name, stock number, unit of issue, minimum, ordering and maximum points. When the item is issued the date of issue goes in the "Date" column, quantity issued goes in the "Issued" column, to whom issued goes in the "To" column. The amount issued is then deducted from the previous balance on hand and entered as the new balance on hand. This posting is done in blue or black. When an item is received it is entered on its inventory card in red. The date it was received goes in the "Date" column, the quantity received goes in the "Issued" column, the "To" column is left blank, and the quantity received is added to the previous balance on hand and entered as the new balance.

The bottom of the card has spaces for the stock number, item name, month in which ordered and the minimum, ordering and maximum points. When an item is ordered a small colored flag is inserted in the bottom of the card holder covering the month in which it was ordered. A transparent colored slide indicator is inserted in the right hand side of the card holder. As stock is issued this slide is gradually moved to the left until it reaches the ordering point at which time a purchase requisition is instituted. The slide continues to move to the left until the stock is received; it is then returned to the maximum point. The flag is removed from the month at this time also. If the minimum point is reached before the new stock arrives steps must be taken to expedite delivery.

With this method of stock recording the condition of the stock is instantly available.

The purchase record and consumption record cards as shown are, I believe, self-explanatory.

To get the most from perpetual inventory records they must contain all the following information:

1. Stock number, name of item and some description of it.
2. The minimum and maximum to be kept on hand.
3. The order point.
4. Quantity and specifications ordered and date (entered in records as soon as possible after purchase order is made out). Established specifications are noted on consumption record card; any deviation from these specifications is also noted.
5. Quantity and quality received and date (entered when received). Any discrepancies are noted on the purchasing department, storeroom or receiving department copies of the purchase order.
6. Quantity issued and date (entered daily).
7. To whom issued and date (entered daily).

8. Balance remaining on hand.

9. From whom purchased (vendor) and purchase order number (entered at same time as point 4). Purchase requisition may be filed with purchase order or separately. In either case it must be preserved for future reference.

10. Unit price and extension (entered from invoice only).

11. Unit of issue.

12. Monthly consumption (entered monthly).

13. Monthly consumption average for the year (entered yearly).

14. Monthly cost average (entered monthly).

15. Monthly cost average for the year (entered yearly).

16. Quantity received each month (entered monthly).

17. Monthly balance on hand (entered monthly).

18. Date and result of last physical inventory. (It is absolutely essential that inventory record balances be checked against shelf balances at least twice a year, oftener if possible. It is unnecessary to disrupt the organization while taking this inventory as it can be done at any convenient time and not all at once. This checking should, however, be done by qualified personnel only.)

The Order Point

When to replenish stock presents quite a problem at times. However, a careful study of the inventory records will overcome this situation with little difficulty.

The old method of determining when to order new stock by minimum and maximum points does not give satisfactory results. This method has been replaced by the minimum, order and maximum points method. These three points are computed by the rate of usage and the length of time required to replace any one item. It is impossible to arrive at definite replenishment points until the inventory control system has been in operation for several months.

The order point is set sufficiently high so as to allow ample time to replace the stock without dropping below the minimum. The amount of stock purchased must necessarily be of sufficient quantity to bring the stock back to the maximum.

When an item has reached the minimum and has not been replaced the purchasing department must be notified immediately so that steps can be taken to expedite delivery. The minimum is established to prevent stock from running out.

The minimum, order and maximum points must be watched constantly and changed, if necessary, to coincide with any use changes because supplies usage is not constant but variable; this does not apply to any situation definitely known to be of a temporary nature.

Humanizing Hospital Experiences

IN A timely article "Humanizing Hospital Experiences" published in the October 1948 issue of the *American Journal of Diseases of Children*, Grover F. Powers, M.D., states that the doctor should also consider as part of his responsibility the promotion of security and freedom from needless tensions and strains in his patients. To sum up his views in a few words, the author feels that there must be "no taboo on tenderness" in the treatment of patients.

Hospitals, which have so often been accused of being impersonal and mechanized, must attempt a more personal and humane understanding of the patient. The author describes as one means of humanizing hospital experiences "the rooming-in plan" wherein the newborn child is cared for as much as possible by the new mother in her own room. In this way, instinctive reactions are fostered to the advantage of the mother, father and newborn child. The rooming-in plan seems to be growing in popularity as a normal reaction to human cravings of men and women who are about to become parents. The program has educational values for personnel in various departments, such as obstetrics, pediatrics, nursing and administration. The author reports that no harmful complications have developed to date, and that infections among the newborn infants are fewer.

In the outpatient clinic there are at least three areas in which hospital experience can be humanized. The first concerns the preceptors who teach the student. The preceptors must be carefully chosen and must always teach that all types of patients are human beings and need careful treatment, patiently and sympathetically carried out. The second point has to do with the patient's presence at discussions and history takings; the author feels that one should indulge in discussions in the child's presence only when relief and comfort to the patient can result. A third factor deals with hospital administration. The author states that an appointment system in the outpatient department is most important to the management of the child and parent, the rendering of good medical care, and the proper teaching of medical and nursing students.

As far as inpatient procedures are concerned, they can be humanized as follows: when the patient is brought to the ward it would be extremely helpful if the mother would introduce the child to the nurse in charge and tell her about the child's likes and dislikes and his habits. He feels that the favorite toy should always be admitted along with the patient. Parents, too, should be considered when their child is being admitted, and at all times the admitting procedure, history taking, and preliminary examination should be done by thoughtful, sympathetic personnel.

As far as visiting is concerned, the author reports that in his hospital they are trying the plan of daily half hour visits at a stated time when interns are available for interview. Fears regarding visiting as a source of cross-infection are exaggerated. He feels that the family ties should be strengthened not weakened at this time. Coddling and attention by physicians and nurses as well as by parents should be encouraged.

With respect to painful diagnostic and therapeutic procedures, the author thinks that all children should be prepared for procedures, painful or otherwise, by the intern and nurses working in harmony. He feels that it is better to prepare a child for what is to come rather than to "spring" something on him and have him lose faith in the members of the staff. Physical examinations should be done at an opportune time. Examinations done under duress are unsatisfactory at best. It is better to spend a little time in getting acquainted since it often saves later delay and pain, and may prevent the development of antagonism to the medical staff.—IRVING GOTTSEGEN, *Montefiore Hospital, Country Sanatorium, Bedford Hills, N.Y.*

All a supervisor has to do

TO BUILD AND MAINTAIN MORALE

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IN HIS text, "Human Nature and Management," Ordway Tead defines morale as "that attitude which results from mobilization of energy, interest and initiative in the enthusiastic and effective pursuit of purpose."

The purpose of this discussion is to establish the means by which a supervisor can maintain morale in the group for which she is responsible. First we must acknowledge that the supervisor should not be expected to create morale in spite of management but should coordinate and harmonize the function of her department with the complete organizational program. It is understood that she is responsible for creating morale in her own group, but in doing so she should have the wholehearted support of management. We will assume that the supervisor is well prepared to carry on her professional responsibilities. We all know there are many such persons but some of them have considerable difficulty in stimulating and sustaining morale

TOOL OF MORALE

Of primary importance as a tool of morale let us place first acquaintance with the organizational chart. One industrialist informed me that he thought each worker, at the time of employment, should be given an organizational chart. However, the chart of itself is of little value if the worker is not acquainted with its use. First of all, each worker must know *to whom* and *for whom* he is responsible. This can be accomplished at the time of employment by careful and detailed orientation of the employe.

Next, it is important that each worker realize that any position on the organizational chart carries a two-way function. He must be acquainted with the objectives and policy from above, and in return he should relay information to his superiors. In the case of the supervisor, she should relay information regarding the policy of the hospital to those in her charge, and she should return to management the problems in personnel management and other questions pertaining to the well-being of the institution. Frequently we find employes who have the mistaken idea that returning information reflects on their ability, or is tattling. The supervisor should have the ability to screen the information going in either direction, placing responsibilities in their proper channels.

By way of explanation let us picture the earnest head nurse who is diligently trying to cover a service and serve the medical staff although there exists a serious shortage of help. Perhaps she has the feeling that if she reports the shortage she may be criticized for inability to manage her ward. Through her knowledge of individual abilities and in a spirit of understanding, the supervisor might be able to show this head nurse the benefit she would receive from reporting her difficulties. With such a report the supervisor should evaluate the situation, placing the responsibility where it belongs:

1. If she finds the department needs increased help, she should furnish it if possible. If such assistance is not available, she should relay the need to her superior, who in turn follows a similar procedure.

2. If she finds that the head nurse has failed to meet the requirements because of inability to manage, perhaps she can assist her in establishing more satisfactory methods of allocating duties and making out time slips. Eventually, if such assistance fails it may be necessary, in the interests of all concerned, to replace the head nurse.

Failure to place responsibilities in their proper channels results in workers who are continually frustrated in their efforts of accomplishment and destroys morale very quickly in any group. However, the lowered morale is not the most serious result of improper allocation of responsibilities. Such circumstances may result in serious accidents, or even in legal complications as a result of such accidents. The analysis of the situation is generally that the conscientious, earnest worker assumes responsibility which she is unable to carry, or which should be referred to proper authorities—a judicious use of the "buck-passing" procedure certainly has its merits.

CLASSIFICATION OF GROUPS

1. Each worker worthy of his hire is entitled to identification of his position. This builds morale by creating self-satisfaction and may be carried out by use of a distinctive uniform, name plate, or any means which identifies the individual to other members of the group and to persons from outside the institution.

2. Each employe should be given authority to match the responsibility that he must assume. In addition to that, each employe should receive compensation commensurate with the responsibility which he must carry. As an example of this situation I should like to call attention to the duties and compensation of the night supervisor. She is called upon to carry the responsibility of superintendent of nurses; supervise admissions; make financial arrangements for admission, and work with medical staff problems. In an emergency, she may be called upon to act for the superintendent in making an immediate decision, yet she is rated as supervisor in both salary and title.

3. Each employe should have a feeling of security, of sharing in the general program. This can be accomplished by fair personnel practices and by sharing information of management with personnel.

CONFERENCE METHOD

The conference method has long been recognized as the best means of coordinating interdepartmental responsibilities and functions. However, care must be taken to conduct the conferences so as to stimulate constructive solutions to mutual problems. Individual participation should be solicited

Presented at the Association of Western Hospitals meeting, 1949.

SERVICE EVALUATION

FOR GRADUATE STAFF NURSE

Date _____ 19____ For Period

Name _____ Department _____ From _____ To _____

DIRECTIONS: Head Nurse and Supervisor score ratings in right hand columns, add totals and divide by 2 to get average rating.

	1	2	3	4	Head Nurse	Supervisor
1. Attitude	Indifferent Gloomy	Overenergetic Lacks poise	Usually well poised Wholesome	Inspires confidence Stimulating		
2. Vitality	Listless Works with effort	Easily tired	Average activity	Energetic, buoyant Always busy		
3. Personal Health and Hygiene	Neglectful Objectionable to others	Appears to have poor health practice	Sound health practice	Excellent example of good health		
4. Appearance	Untidy	Does not maintain professional appearance	Usually well groomed	Immaculate Always well groomed		
5. Manner	Antagonistic Argumentative	Casual Indifferent to direction	Accepts criticism Not consistent in response	Harmonious worker Shows keen interest		
6. Sympathy and Interest	Disinterested Bored and unobservant	Personal likes influence response	Willingly helps when directed	Interested in people Anticipates patient needs		
7. Punctuality	Frequently late	Occasionally late	Seldom late for duty or reports	Always punctual		
8. Rapidity	Wastes time in purposeless effort	Slow Routine worker	Carries assignments easily	Quick and reliable		
9. Work Organization	Does not plan work	Needs direction in planning	Plans work well Completes work	Excellent organization Meets emergencies		
10. Personal Relations	Irritating Creates resentment	Does not win cooperation	Usually tactful Gets cooperation	Very tactful Wins confidence of patients and workers		
11. Adaptability	Adjusts slowly to new assignments	Needs supervision in new situations	Carries new work easily	Able to form new plans well		
12. Technical Skill	Careless and awkward	Moderately skillful	Good technique	Excellent technique Very skillful		
13. Reporting	Does not report unfinished work, etc.	Forgets important details	Reports complete and dependable	Prompt and accurate reports		
14. Dependability	Often not reliable	Assumes unwarranted responsibility	Usually reliable	Most dependable Wins confidence of staff		
15. Care of Hospital Property	Careless and destructive	Extravagant Misuses supplies	Economical and careful	Very careful Suggests new economies		
16. Honesty	Conduct evasive and questionable	Gives impression of superficial accomplishment	Usually frank and honest	Honesty above reproach		
17. Loyalty	Fault finding Discontented	Critical of management Varies in loyalty	Usually loyal and sincere	Enthusiastic loyalty		
18. Cooperation	Creates antagonism Dictatorial attitude	Usually cooperates with other workers	Courteous attitude Wins willing cooperation	Secures unusual cooperation		
19. Judgment	Poor judgment Does not weigh values	Good judgment in normal condition	Makes reasonable decisions	Always capable of making sound decisions		
20. Initiative	Avoids responsibility Needs guidance	Capable of performing routine duties	Able to form her own plans of execution	Takes initiative in organizing work		
21. Leadership	Fails to attract confidence of others	Leads well with limitations	Good leader Attracts subordinates	Inspires others by example and interest		
22. Executive Ability	Plans only her own work	Helps plan work for others	Feels responsibility for welfare of department	Feels her responsibility to the hospital organization		
23. Social Adjustment	Does not appreciate social attitudes	Reluctantly assumes social responsibilities	Meets social responsibilities well	Tactful, gracious, and well poised		
24. Ambition	No interest in greater responsibility	Fails to take advantage of opportunities to advance	Makes use of opportunities to learn	Exceptionally eager to attain advancement		
25. Teaching Interest	No interest in teaching	Occasionally shows interest in an opportunity to teach	Frequently offers instruction to students and other workers	Enjoys opportunity to take part in ward teaching		
				TOTALS		

This report has been discussed with me _____ Supervisor

Signed _____ Staff Nurse _____ Head Nurse

and freedom of speech by all members of the group should be encouraged. Every effort should be made to avoid personality conflicts and great care should be taken to prevent the conferences from becoming "gripe" sessions. Often the extreme interest the supervisor may have in her own department may cause her to become an isolationist. This circumstance does not build morale in a group, but her participation in the conference which promotes greater understanding and tolerance of other departmental problems is most constructive.

The next means I should like to suggest is the following:

WRITTEN RECORD

Without a written record the efficiency of the department is based on personal judgment of the supervisor. The record then is only as good as the memory of this individual and is entirely lost to any other member of the staff. It leaves the supervisor open to charges of favoritism and partiality. On the other hand, a written record, which is reviewed by employe and supervisor, is a constant source of information and satisfaction to both the worker and the supervisor.

The first record suggested is an evaluation of service. This record should be made out at regular intervals, and on completion should be reviewed by employe and supervisor in joint session. If the analysis of the report is objective and fair, it should provide satisfaction to both parties in the following ways:

To the employe:

1. It is a yardstick of efficiency.
2. It gives credit for accomplishment or challenge for improvement.
3. It indicates need for further training.
4. It produces more work satisfaction.

To the employer or supervisor:

1. It is an accurate measurement of worker's abilities.
2. It affords opportunity for best placement of personnel.
3. It should promote greater stabilization of workers through satisfaction in work.
4. It prevents criticism of partiality and favoritism.
5. It provides a written record of efficiency on which to base salary increases, promotions or dismissals.
6. It gives legal protection in case of accident.
7. It serves as reference for recommendations and rehiring.

Scott and Clothier, in analyzing problems of personnel management, state that if we could hire people the way we buy machines our personnel problems would be greatly simplified. That is quite true, but just imagine how impersonal and monotonous the program would become. It is the constant challenge of individual peculiarities that stimulates us to our best efforts. Ordway Tead summarized the creation of morale under these headings:

1. Good physical health (needed energy).
2. Good mental health (essential to effective leadership).
3. Explicit purposes known and believed in by the group.
4. Knowledge of the impressive traditions of the group.
5. Adequate knowledge of technic by each member.
6. A sense of fair treatment in relationships with others in the group (records).
7. A reasonable sense of permanency of one's tenure in the group. (Any feeling of insecurity, real or fancied, is damaging.)
8. A sense of being recognized as partners *in* and not as servants *of* the group.
9. Clear identification of each as a member (uniforms, pins.)
10. Knowledge of the results of each individual's and the whole group's progress (records).
11. Conscious organization of approval of good results.
12. Some participation in the results of the efforts of the group.
13. Conscious assumption of responsibility by every member of the group.
14. The elimination of unfounded rumors.

With such instruments as correct organizational placement of the supervisor, of keen understanding of her responsibility, acknowledgment by management of her efforts and accomplishments, security on the job, and participation in the group function, the supervisor may be expected not only to sustain morale in her group but also to add much to the morale of any organization.

An Administrator Interprets

THE GROWTH OF THE X-RAY DEPARTMENT

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SO MUCH has been written on the various phases of hospital management one might conclude that everything worth while has already been written. However, on reviewing the literature it would seem that the x-ray department has not always been given the attention by the administrator that its importance warrants.

Adequate supervision in the modern hospital has become increasingly complex. The complexity of some of the problems is probably not generally appreciated, even by hospital administrators themselves. As a matter of fact, some departments have become so highly specialized that no one person can hope to cope with all the details of each. This is especially true in the department of radiology where new demands for specialized services bring up problems of ever increasing magnitude.

The place of the x-ray department in the modern hospital is well expressed by Dr. Maximilian J. Hubeny, director of one of the largest x-ray departments in the United States:

"The hospital is rapidly becoming the focal point of all medical practice, and one result of the many changes taking place is that the x-ray department is being given new and extraordinary importance."

TAIL WAGS DOG?

While the importance of the x-ray department, large or small, is no longer questioned, the extent of this importance is still perhaps not generally realized. It may be deplored by some of the older generation, yet the fact remains that the hospital almost revolves around its laboratory work. To some it may seem like "the tail wagging the dog" but whether one approves or disapproves, the situation does exist and must be faced. The phenomenal growth of laboratory services now demanded in the hospital, large or small, has so greatly increased the complexity and diversity of the work of the administrator that division of work is essential. Thus, the choice of personnel is of primary importance. Nowhere is this better exemplified than in the x-ray department.

Before considering in detail some of the problems in connection with the x-ray department, I am tempted to reminisce and to recall the time when only 20 years ago the x-ray department of the hospital with which I am associated consisted essentially of one large room where radiographic, fluoroscopic, and therapeutic work were combined. There was, of course, a small developing room and office. The stenographer sat at the end of a corridor which also served as a waiting room, that is, when more than one patient happened to arrive at the same time.

The present x-ray department of St. Joseph's Hospital, St. John, N.B., offers quite a contrast. This department today occupies nine rooms not including dressing rooms. These rooms contain the latest shockproof equipment. For x-ray therapy there are three machines; two are used for deep x-ray therapy and one for superficial therapy. For diagnostic work there are two high powered generators with motor driven tables and rotating anode tubes for both fluoroscopy and radiography. A separate shockproof generator is used in the urographic room with a rotating anode tube. In addition to this equipment there is a mobile unit for bedside radiography and a photo-roentgen unit is now being installed for routine chest films on all patients admitted to the hospital. Incidentally, a completely equipped room for clinical photography is also being installed.

This picture is given merely to show the progress that can take place even in a small hospital of less than 150 beds. This is not an isolated instance of growth. Had it been anticipated and had provision been made in the original planning of the institution, much expense and labor could have been saved. It may be of interest and of some value to try to analyze the present status of x-ray departments to see what lessons can be gained, how mistakes can be avoided, and how further progress can be made.

It might be well to consider the x-ray department under the following headings: the directing radiologist, technicians, secretarial staff, apparatus, and housing.

PERSONNEL IS PARAMOUNT

As mentioned previously, the hospital administrator must realize that adequate personal supervision of all departments is utterly impossible. The choice of personnel, therefore, is of paramount importance. The director of the department of radiology must be a physician who has had adequate training as a specialist in radiology and whose integrity and judgment are of high order. The wise administrator will endeavor to obtain the services of such a person and will leave many of the problems to his discretion. A minimum of interference will then be necessary and the interdepartmental relationship can be a very happy one.

Actually, this can apply to the entire hospital. The administrator, of course, must know enough about the problems of the various departments to cooperate intelligently and to realize that sometimes courageous and radical steps must be taken if the proper standards are to be maintained. The matter of salary may seem at times almost prohibitive but if the proper person is obtained a good salary will be fully justified.

Second in importance only to the radiologist are his technical assistants. With the increased variety and volume of x-ray work a steady elevation in standards of education and training for x-ray technicians has become imperative. This is a problem that has

come to the fore quite recently, and as yet comparatively few administrators have given it adequate consideration. On first thought it might seem that this matter does not concern hospital administrators, but actually it does. It has become evident that the proper training of technicians is vital, but the problem has become too much for the radiologist to handle alone so that some cooperation is essential. It is somewhat similar to the matter of training nurses.

For many years the responsibility of the hospital for training nurses has been accepted and is now taken as a matter of course. But only recently is it being recognized that a similar joint responsibility exists in the training of student x-ray technicians. As yet not all hospital administrators are cognizant of this fact. Where a full-time radiologist is employed he should be encouraged and assisted to establish and conduct courses for student technicians. The senior technician must have extensive training for this position in order to act as an intelligent assistant to the radiologist.

The secretarial problem has also become more complex. Better records now demanded require the assistance of a thoroughly trained office staff. The secretary should, if possible, have training in medical terminology and she should also have executive ability because much of the smooth functioning of the department depends upon a competent secretary. The competent secretary must have a sound knowledge of the intricate workings of the department in order to arrange appointments, answer telephone calls, and find reports and films for staff physicians. It is a position that requires intelligence, training and tact.

Perhaps next in importance to personnel is the selection of adequate apparatus. This is not an easy problem and should be left in the hands of the radiologist to a great extent. The hospital administrator should be prepared to spend a rather large sum of money, even in a small hospital, to provide space and equipment. Both are costly, and the needs are becoming increasingly complex. Recommendations for equipment are given in the report of the A.H.A. Institute on Hospital Planning and by other authorities. It is my belief that many recommendations are too conservative and that provision should be made for more than one radiographic room in all but very small so-called "cottage" hospitals, even if not all the rooms are fully equipped at first.

CONSIDER THE HOUSING PROBLEM

The proper housing of x-ray equipment should be given careful consideration. Here, as previously mentioned, an eye to the future is essential if costly changes resulting from growth are to be avoided. Twenty years ago, few persons foresaw the great increase in demand for hospitalization and for x-ray services. Consequently, many hospitals and x-ray departments soon became too small, necessitating radical changes or, in many cases, relocation. Hospital administrators should check all plans for hospital building very carefully to see that there is provision for expansion. Fortunately, architects are now doing better planning. In a short paper one cannot consider details to any extent. All hospital administrators should read the excellent publication, "A Manual of Desirable Standards for Hospital Radiological Departments," published by the American College of Radiology. There is a wealth of information in this booklet that cannot be discussed in a short paper.

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Syringes Sterilized Centrally

A CENTRALIZED method of sterilizing syringes, always a thorn in the side of the proponents of centralization in hospitals, has been devised by Dr. John Murray, director of pathology, Queen Charlotte's Maternity Hospital, London, and described in the issue of *Lancet* for September 3.

The procedure he outlines for sterilizing many syringes together in a box is simple. These boxes can be easily and cheaply made of copper, plated if necessary, with a hinged lid and hasp. Inside are two pairs of ¼ inch ledges, an upper pair running from front to back, and a lower pair running from side to side. All-glass syringes are hung through holes in a removable metal shelf resting on the upper ledges, with their needles mounted and plunged through a thick pad of gamgee tissue supported at the level of the bevels of the needles by the lower edges. This pad is made from a piece of tissue sewn over a rectangular wire frame and fits snugly all around to the sides of the box. For use, the cleaned syringes are dropped through the holes in the shelf, so that their needles penetrate the cotton-wool pad, and the box is sterilized in the hot air oven at 160° C. for one hour. The needs for each ward must be investigated, and boxes of an appropriate size to carry the requisite number of syringes to cover the average day's work can be made.

The needles, the author explains, are protected mechanically and bacteriologically by the pad of gamgee tissue, and the complete outfit will remain sterile for at least a day, even though the lid is often opened. In practice, it seems necessary for the set to be resterilized at the end of each day, and for each ward to have two boxes, one in use, the other being sterilized. The ward personnel would then only need to rinse a syringe after use and place it in a separate receptacle.

Hypodermic syringes, the author continues (1 and 2 cc.) are conveniently sterilized in sets of 20, in boxes measuring 6 by 5 by 6 inches, and twelve 5 and 10 cc. syringes can be accommodated in similar boxes if the depth is increased to 8 inches. It is unsatisfactory to sterilize large and small syringes in the same box.

The author believes that some may consider the initial expense discouraging to the introduction of such equipment, but, since most authorities agree that a centralized syringe service is ideal, the method suggested here involves no more expense than does the preparation of syringes in separate containers. On the other hand, he claims, the adoption of the system should result in a great saving of labor and a reduction in breakages of syringes.—MALCOLM SMITH, *Montefiore Hospital, New York.*

STUDENT NURSES EARN WHILE THEY LEARN

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THE history of nursing education in the United States is an interesting story of progress and development. Today we are removed sufficiently from the beginnings of this modern era of nursing to see how the present pattern evolved and to see that we have reached a transition period that will carry us to new levels, perhaps sooner than we anticipate.

Problems in school organization, educational control, and financial support are being scrutinized carefully by hospital administrators and by nursing educators. The next few years are likely to bring important decisions; trends are beginning to crystallize; thought-provoking questions are demanding attention. Many have accepted two principles for the future of nursing education: (1) sponsorship in educational institutions, and (2) defined budgetary control. Transitional steps will be needed to bridge the gap from present practice.

This article is intended to suggest two procedures that seem in harmony with these trends. The first, arrangement of classes in concentrated periods, is based upon six years of experience. The second, a plan of financing for the student, was offered for the first time to students who entered the school in September 1947. We suggest these plans as logical steps to take at this time.

Mount Auburn Hospital is a voluntary agency with 221 beds and 51 bassinets. The school plans for an average enrollment of 150 to 180, admitting 30 students twice a year.

ARRANGEMENT OF CLASSES

There are three class periods: the preliminary and junior periods which cover the first six months of the curriculum, the intermediate period of nine weeks at the beginning of the second year, and the senior period of four weeks during the last year. All formal classes are given during these periods when students are really "in school" on regular schedule with time allowed for daily preparation. Between class periods, students are assigned for full-time ward duty with an informal ward teaching program that applies classroom instruction in daily practice. The time schedule is shown.

First Year

PRECLINICAL CLASS PERIOD (20 Weeks)

Subjects Taught	*Hrs.*	*Credit*
Anatomy and Physiology	95	5
Microbiology	45	3
Chemistry	45	3
Pharmacology I	25	2
Nutrition, Foods and Cookery	45	3
Nursing Arts	160	6
Advanced Nursing	20	2
Professional Adjustments I	21	1
Laboratory: Ward experience under instructor's supervision, 60 hours	456	25

JUNIOR CLASS PERIOD (5 Weeks)

Subjects Taught	*Hrs.*	*Credit*
Pathology	15	1
Pharmacology II	30	2
Diet Therapy	20	1
Medical-Surgical Nursing (Integrated Introduction)	70	4
Psychology	15	1
Laboratory: Ward experience under instructor's supervision, 60 hours	150	9

Students competing this portion of the work successfully are "capped" and accepted into full standing in the school of nursing. Following a vacation of one week, they get 23 weeks of clinical experience on wards (no formal classes) and ward teaching. A three-week vacation period is arranged at the convenience of the nursing service.

Second Year

INTERMEDIATE CLASS PERIOD (9 Weeks)

Subjects Taught	*Hrs.*	*Credit*
Advanced Medical-Surgical Nursing	26	1
Neurologic Nursing	8	½
Venereal Disease Nursing	7	½
Tuberculosis Nursing	5	½
Gynecologic Nursing	12	½
Urologic Nursing	10	½
Orthopedic Nursing	13	½
Obstetric Nursing	37	2
Pediatric Nursing	39	2
Emergency Nursing and First Aid	16	½
History of Nursing	15	1
Public Health Nursing	11	1
Ward Teaching and Management	4	½
Sociology	15	1
Laboratory: Ward experience under instructor's supervision: Obstetrics, 36 hours Pediatrics, 36 hours	218	12

Then follow an eight-week affiliation in medical nursing; 32 weeks of clinical experience in the home hospital (no formal classes), and a ward teaching program. A vacation of three weeks is arranged at the convenience of the nursing service.

Third Year

The schedule calls for a 13 week affiliation in psychiatric nursing and 32 weeks of clinical experience in the home hospital (no formal classes) with a ward teaching program. A three-week vacation period is arranged at a convenient time.

SENIOR CLASS PERIOD (4 Weeks)

Subjects Taught	*Hrs.*	*Credit*
Dermatologic Nursing	8	½
Communicable Disease Nursing	17	1
Eye, Ear, Nose and Throat Nursing	20	1
Home Nursing	15	½
Sanitation	14	½
Professional Adjustments II	18	1
Ward Teaching and Administration	4	½
	96	5

The total of 87 weeks of clinical experience in the three years (23+32+32) includes these special services:

	Weeks
Obstetrics	16
Pediatrics	16
Outpatient Department	6
Operating Room	12
Diet Kitchen	4
	54

The remaining 33 weeks are spent on medical-surgical floors to bring the total medical days to the required number (120 days). Since our services are heavier in surgery than in medicine, this takes longer than would be the case with segregated services. If there is free time after meeting this requirement, students may state their preferences for additional experience and, so far as possible, are assigned accordingly. This gives opportunities for advanced instruction and senior responsibilities in specialized fields of their choice. An affiliation in eye, ear, nose and throat nursing is available for six students per year. Occasionally, a student who expresses such desire may start a two-point course in a neighboring university during this period, which starts her on a graduate

career a little ahead of the expected time.

Fourteen days' sick leave is allowed in the three years. The student must make up any time lost beyond this allowance.

PLAN OF FINANCING

Believing that instruction in the art and science of nursing is education on a level equal to collegiate instruction, we recognize that certain principles common in college practice can be used to equal advantage in a school of nursing.

1. Students beyond secondary school level are adults and should be expected to conduct themselves accordingly.

2. College students make their own arrangements for shelter and food. Those who can commute and be on time for classes and assignments may live at home.

3. They make provision for health needs, through hospitalization insurance or dispensary service.

4. They provide the textbooks needed for the courses that they choose.

5. They pay tuition based upon hours of credit necessary for graduation.

6. They replace laboratory equipment when they break it.

7. If any special wearing apparel is required, the students furnish it.

8. Students who cannot meet the college expenses otherwise supplement their personal funds by gainful employment during the college year.

The student of nursing can make use of these principles, too, under this financial plan.

1. She takes responsibility for meeting her own expenses, item by item, and receives remuneration for her services.

2. She makes her own arrangements for shelter and food. If she wishes to live in the nurses' residence, she may rent a room at $5.50 a week. She eats in the hospital cafeteria, and pays for what she chooses, as hospital employes do. If she can manage commuting, she is free to live at home.

3. She pays an annual health fee that includes physical examinations, x-rays and Blue Cross, totaling $20 a year.

4. She buys her texts as she needs them.

5. She pays tuition, at the rate of $10 a credit hour. Basis of subject evaluation was approximately 18 hours of lecture per credit hour, and three hours of demonstration, laboratory or practice to equal one lecture hour. (Twelve or 14 hours a week of ward practice under instruction during the intermediate and senior class periods reduces the credit hours for those subjects.)

6. She pays for broken articles of equipment, syringes, thermometers and such items.

7. She pays for her uniforms at cost, and for laundry of uniforms at $1.15 per week if she wishes to send them to the hospital laundry. She may make other arrangements for laundry if she chooses.

8. When she renders nursing service in the hospital, apart from the class periods, the hospital pays for her services.

REMUNERATION OF STUDENTS

Remuneration starts in the second half of the first year, at the rate of $0.65 an hour and continues until the student enters the intermediate class period, excluding vacations and sick leave. The rate for second year students is $0.70 an hour; for third year students, $0.75 an hour. These rates were fixed arbitrarily, with thought of some proper relation to the minimum hourly wage that we pay to auxiliary workers.

We have asked for no modification of previous arrangements with the schools in which our students affiliate. For these short periods, maintenance and instruction may be considered to balance nursing service rendered.

Summary of Financial Arrangements

Estimated Costs to Students	
Tuition	$ 500.00
Books	50.00
Health Fees	60.00
Uniforms	50.00
Breakage Fee	10.00
Room—125 weeks	437.50
Food	1,093.75
Laundry—125 weeks	143.75
	$2,345.00

Remunerations	*No. of Weeks*	*Hrs. per Week*	*Rate per Hr.*
1st Year	23	48	$0.65
2d Year	32	48	$0.70
3d Year	32	48	$0.75

This makes a total remuneration of $2944.80 per student: $717.60, the first year; $1075.20, the second year, and $1152, the third year.

The student is asked to vacate her room when she leaves for a vacation or for affiliation. Therefore, there is no charge for the room during these periods unless the student makes a special request for reservation.

COMMENTS

Seven years' experience with this type of class arrangement has convinced us of its merits. Students enjoy their classes because they have time for adequate preparation. Instructors find them alert and interested, ready with intelligent questions. The plan eliminates the proverbial rush from ward to class and back again, with consequent fatigue and error. It also eliminates the conflict between night duty and daytime classes. Our students return from affiliations in which the traditional plan is used, enthusiastic about their own school in contrast. Their health is improved.

The financial plan was arranged to fit with the class arrangement. It is a newer development; we cannot report results. It seems logical and reasonable on the following bases:

1. The student learns independence and self-discipline by handling her own money.

2. She has incentive to work toward the period of remuneration.

3. She carries the financial risk during the early months. If she fails, the hospital has not invested money in instruction and maintenance without return.

4. Current accounting is better than the assumption that instruction and maintenance costs balance service rendered.

This type of financing is elective at the present time. Ten out of 29 students chose this plan in the first class to which it was offered. Fifty per cent of the second class accepted it. We believe that its advantages will be clear once we have carried a class through the three-year period.

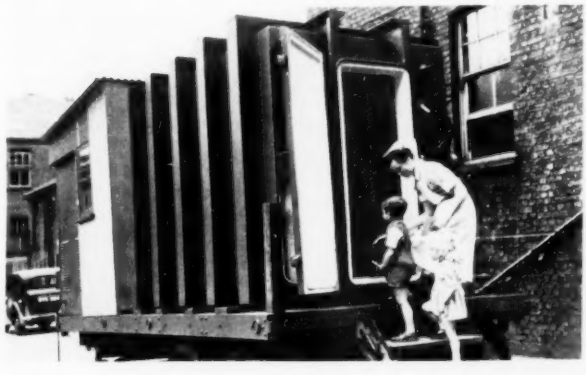
Do we look forward to a day when educational institutions will sponsor and support nursing education? If so, can we begin to prepare for it by arranging the curriculum in logical sequence and by keeping an exact accounting on a business-like basis? Is not a pay-as-you-go arrangement better for the student than adding a monthly stipend to the accounting assumptions in present practice? Perhaps it will prove to be better for the hospital budget, too.

Why not pull out those hidden costs that have masqueraded to make you believe that your school of nursing was providing "cheap" nursing service for your patients?

Left: Chaplain Robert Leslie of the Boston State Mental Hospital addressing a session of the American Protestant Hospital Association in Cleveland. Listening intently are (l.) James Burns, chaplain, Massachusetts General Hospital, Boston, and (r.) John Dudley, administrator, Houston Memorial Hospital, Houston, Tex.

The latest in uniforms for nursing students was designed for students at Passavant Memorial Hospital, Chicago, by Mainbocher. Mrs. Leon Mandel models the uniform of pale gray with white piping, and the diaphanous nylon dress apron designed to go with the uniform. For outdoor wear, Mainbocher designed a dark gray wool coat, with matching hat.

H. Carl Prange, chairman of the board of directors of Sheboygan Memorial Hospital, Sheboygan, Wis., accepts the beautiful memorial chapel from Rev. T. Parry Jones, chairman of the chapel building committee. The wood carving was done by Alois Lang, famous Bavarian artist, who designed the carving for Rockefeller Chapel at the University of Chicago.



The British are using mobile decompression chambers to help cure children suffering from whooping cough. At right a nurse enters the chamber which has been installed at Park Hospital, London, with two patients.

SMALL HOSPITALS HAVE

1. What Is Expected of Them

ELIZABETH SIMMERMAN
Hospital Field Consultant, Hospital Division
Kentucky State Department of Health

SO many individuals and groups, all of them of equal importance, expect so much from the small hospital, that each one must be given consideration. By "the small hospital" I mean not the small hospital in a city, but the hospital in a small community or rural area. The ideal small hospital is the one held by a nonprofit corporation as a public trust, admitting patients without restriction as to race, creed, color or economic status, open to all physicians in good standing, and equipped to serve patients suffering from as wide a range of disorders as the local physicians are competent to treat.

The patient expects to receive good hospital care at a rate which he can afford to pay. In order to know that his care is of the best, he should have the assurance that the hospital is making every effort to meet the recognized standards for good hospital care and is endeavoring to qualify for approval.

A program of standardization is conducted by the American College of Surgeons with the idea of giving the patient the best professional, scientific and humanitarian care. In order to effect this it is required of the institution that it have an organized, competent and ethical medical staff; that the staff hold regular conferences for review of the clinical work; that fee splitting be barred; that accurate and complete records be kept of all patients treated, and that adequate diagnostic and therapeutic facilities, including a clinical laboratory and x-ray department, be provided.

There is no law or statute to force hospitals to meet these standards. There is an unwritten law, however, that condemns isolationism as a hospital policy. Problems of small hospitals in maintenance of high standards, difficult as they are, can be solved by help from other hospitals through their local councils, state associations, and national medical and hospital organizations. When the individual recognizes that the hospital in which he is a patient is a member of such organizations and is attempting to comply with the standardization program, he can feel he is in safe hands. Of course, we realize that while the scientific aspect is most important, it must not overshadow the humanitarian spirit of the institution. The patient in a hospital is an individual and, therefore, he cannot be standardized.

To progress from the individual patient, we must consider what the community expects of a hospital. A hospital is a visible and tangible investment by the community in the care of its own sick and injured. The opening of a well appointed hospital in a town for the first time changes the condition under which medicine has been practiced. The community which brings about such changes should use them to its own advantage and, at the same time, must take the responsibility for the possible consequences. The hospital then is an agency for the care of the sick, in which the medical re-

(*Continued on Page* 86.)

These papers have been condensed from addresses presented at a symposium on small hospitals, Kentucky Hospital Association meeting, 1949.

3. Kinks in the Hill-Burton Act

YEARS ago the day passed when our hospitals, small or large, could withdraw to a wooded hill top and content themselves in the high-mindedness of their purposes and the relief they afforded to the sick and injured brought to their doors. "Brought to their doors" is an accurate expression because few came by choice until distress laid them low. The processes of social evolution and many other influences transformed the hospitals into institutions essential to the life and health of many of the people at any one time, and to all of the people at some time.

As an institution closely identified with its community the hospital faced the task of organizing four bodies of people into interacting and complementary relationships. Their respective privileges and responsibilities must be definitely set forth in the interest of one primary aim, adequate and improving service for the patient.

First, the community assumed the obligation of support and maintenance, and exercised control through election of the governing board. Second, the board, speaking for the community and in furtherance of its purposes, supervised the conduct of the institution. Third, the medical staff, in return for the privilege of using a superior workshop with adequate facilities placed at its disposal, accepted the responsibility of medical service. Fourth, the administrative and staff personnel were held accountable by the board through its executive officer for proper performance of its varied duties.

The small hospital, however, was not too long in discovering three harsh facts: first, it was too few in number and too restricted in scope to care for all the hospital needs of all the people who depended upon it; second, its costs were too high to permit ready access to its services, and third, its ceiling of quality was too low and raising

SPECIAL PROBLEMS: Symposium

2. Successful Administrative Practices

SISTER MARY REGINALD, R.S.M.
Administrator, Mercy Hospital and Sanitarium
Dyer, Ind.

THERE is a great difference between the physical and the moral size of a hospital. We have all undoubtedly known of physically large hospitals that have been scientifically and humanly small. Likewise, we have known of physically small hospitals that do big work scientifically and humanly, and administratively. It is essential for administrators of physically small hospitals to keep this evaluation in mind in order to motivate them in achieving the best in sound administration.

Successful administrative practices must be based upon a sound philosophy of life concerning administrative responsibilities. It is necessary that we establish principles upon which to build our intellectual and practical foundation of hospital administration. We cannot allow ourselves to be guided by expediency. Philosophy in its true meaning includes both science, the knowledge and explanation of things, and wisdom, that is, prudence, moral integrity—toward self and toward humanity in all walks of life—and Christian fortitude.

With a true philosophy of our work as administrators we will do the necessary fundamental things that will lead to success. Actually, successful administrative practices touch every phase of hospital administration. These practices presuppose some knowledge of all departments, both moral and scientific, even though that knowledge is of necessity somewhat superficial concerning some departments.

We must constantly study and be alert to opportunities in our surroundings. This does not necessarily mean formal courses of study. It does mean study of the official hospital journal and other magazines, nursing journals, manuals, digests and releases. All hospital administrators should spend some time in at least browsing through some of the better magazines or books that anticipate possible social and economic

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GEORGE W. EUTSLER
Director
Holston Valley Community Hospital
Kingsport, Tenn.

it through its own unaided resources was almost impossible. It learned that it could hope to do only in association with other hospitals what it could not accomplish singly, and as an institution which itself represented a cooperative organization of individuals, it banded with others in joint attack upon common problems.

The first fruits of this awakening were the organization of the Commission on Hospital Care by the American Hospital Association in 1943, and the American Hospital Association's 1944 program supporting government aid in hospital construction and for the care of the indigent, and the extension of voluntary budgeting for the costs of hospital and medical care.

The second harvest was the Hill-Burton Act passed in 1946. With its passage Congress wrote into law the principle of government cooperation with local, autonomous hospitals. Thus our hospitals were cut loose overnight from relatively secure moorings within their own communities and cast upon a tide of expansion and interrelationships running toward the distant shore of integrated hospital service for all the people.

In dealing with the transition of the rural hospital, or perhaps intermediate hospital if it has 100 beds, into a unit of an integrated system, it is necessary to express the gratification of hospital workers for the excellence of the Hill-Burton Act and their general approval of the state agencies implementing it. The surveys of needs upon which state hospital plans are built have exercised a salutary effect. The act is producing new hospitals galore which might not have existed for years. The ideal of integrated regions of coordinated base, intermediate and rural hospitals provides an objective for decades of progress through cooperative effort.

But if the Hill-Burton Act is working a veritable revolution, it is not yet a whole or perfect solution. Indeed, it can inflict handicaps upon hospitals and introduce disturbing elements beyond our expectations. For hospitals, as for other individuals and institutions in a free society, eternal vigilance is the price of liberty. I cite these considerations as a challenge to your vigilance.

1. The tendency, in practice if not in theory, for state hospital plans to favor the development of public hospitals, city or county, rather than nonprofit hospitals, must be checked, and the two kinds of hospitals must be restored to equal status in fact as in law. It is perhaps natural that state health departments, which are usually the state hospital agencies, accustomed to dealing primarily with local units of government, turned first to these political bodies with offers of hospital construction funds. The preponderance of grants to public hospitals in the first two years lends substance to this interpretation.

In most instances, hospitals should be constructed and operated by citizens as a corporate activity truly public in spirit and services, but free from the manipulation and restrictions of polit-

(*Continued on Page* 130.)

What Is Expected of Them

(*Continued From Page 84.*)

sources of the community are mobilized and implemented.

To the physician, the hospital is a place in which he can efficiently apply his own knowledge and also have available for consultation the knowledge of his colleagues. We have, in the past, looked on the hospital as merely a place for the care of the sick or a doctor's workshop, but this is no longer true. It is all that and more. Its duty to the citizens who may never occupy a hospital bed is hardly less important than its duty to those who do. This duty is discharged, in part, through the provision of modern clinical facilities, wherein all qualified doctors of medicine in the community may advance their knowledge of medical science. A hospital has a further duty, whenever possible, of providing well trained nurses and interns to serve the community. It has a duty to the local government to be discharged through close and effective cooperation with public health and welfare officials. It has the moral duty in common with all citizens to provide equally good care to poor and rich alike.

While the hospital cannot be considered solely as a workshop for the doctor, certainly it is his laboratory. Every qualified physician within reach of the hospital should be able to make use of its facilities, and especially of its conferences, for his own betterment. It should serve as a postgraduate course for him. Here he is given a place to work, tools to work with, and skilled assistance. The community's investment in the hospital is an investment in the care of the sick, a function which is shared by the physicians of the community.

The scarcity of physicians in the rural areas is essentially an economic problem and, if adequate income for doctors is supplemented with adequate facilities for the practice of good medicine, many physicians will establish and maintain their practice in rural areas. I should like to stress that reputable physicians in the community who are not on the regular staff have a right to expect some help from the local hospital. They should be invited to regular staff meetings, which should be educational in character. They should have access to the hospital library and should be invited to any teaching classes which the hospital might conduct.

CONSIDER OUR EMPLOYES

Another group, which should be given consideration here, comprises our own employes. Perhaps if we gave a little more consideration to this phase, more could be expected for the other groups. This is particularly true in the small hospital with one x-ray technician, one elevator man, a staff of nurses just adequate to cover the 24 hour requirements—what a problem is created by the absence of but one person! We must try to make every employe think in terms of individual service. This means every admission, every ambulance call, every emergency, every telephone call, every vendor, every relative and friend. The public will then appreciate that the hospital and those employed in it are an integral part of the community and deserve its support.

And now let us consider the hospital division of the state department of health and what it expects of a small hospital. A hospital, however small, is a complicated institution, and to a marked degree its efficiency in planning, organization and management affect the efficiency of the doctor's services to his patient. Failure to plan the structure properly will result in excessive costs in both construction and operation. The hospital should be planned around the functions to be performed.

The advice, counsel and aid of the state agency are available to all communities and all hospitals, large or small. While the state agency is primarily engaged in the administration of federal grants-in-aid for hospital construction, it is equally concerned with all hospital planning and construction. The state plan, drawn up as a requirement of the federal law, is based upon the need throughout the state, without regard to which areas may be able to participate in federal funds.

In return, the state agency expects the small hospitals to avail themselves of these services. The state plan calls for construction of more small hospitals than it does of large ones, and for this reason alone the agency is vitally interested in the proper placing and building and eventual efficient operation of small facilities. It expects the small hospital to become fully aware of its eligibility for federal funds, and of its priority rank for participation in these funds. Wide publicity has been, and will be, given to the state plan and to all rules and regulations, and the state agency will spare no effort in advising on all phases of hospital planning and construction. For those hospitals that do participate in the federal program it will, of course, expect compliance with minimum standards of maintenance and operation as it is required to do by law.

The ultimate objective of the state agency's planning is an integrated system of community, district and base hospitals. The small hospital is the basic unit of such a system, and the success of such a plan depends on the cooperation of all.

Successful Administrative Practices

(*Continued from Page* 85.)

trends and issues because those same trends may have a definite effect upon the hospitals for which we are responsible.

We must be aware of the value of the board of directors but, respect that board as we may, we still should not minimize the needs of our hospitals. Therefore, we should not just accept everything the board suggests without an evaluation of it in terms of the good of our patients and of our hospital. We should know our own minds, the needs of our hospitals, present these needs factually, and listen to and appreciate advice. If the advice is not in harmony with the needs, we ought to restate our views using a little different approach. But, finally, we should accept the board's decisions. These decisions should be incorporated in a follow-up letter to each member of the board, and should also be preserved in the written minutes of the meeting. Thus future effects will revert back to the board.

GOOD RELATIONS WITH PRESS

Good public relations are necessary for small hospitals. They ought to start with our staff, our personnel, our patients, their relatives and friends. We should try to establish good public relations with the local newspapers so that favorable and interesting factual news reaches the public through the newspapers. We should see that unfavorable information, even though factual, is filtered before being released to the newspapers, or suppressed entirely.

Successful administrative practices require a knowledge of purchasing principles. This means study and use of available guides in purchasing, and the courage to buy what is needed. Remember, as hospital administrators we are spending the public's money. There is a wealth of information available on purchasing of a diversity of items—from blankets, sheets and other textiles to surgical needles, canned fruits and vegetables.

Some knowledge of bookkeeping and accounting is essential for all administrators of small hospitals. We must know our daily costs and our daily income, depreciation, our debts, and uncollectible accounts. Another "must" is the understanding of the relationship of good admitting procedures to income.

We are surrounded by employes and need to understand their activities and interrelations. Hence a knowledge of good personnel policies is vitally necessary for us, that we may view objectively the acts and the reports of our personnel. The new "Manual on Personnel Policies" of the American Hospital Association is an excellent treatise on good personnel principles and policies. If we have a personnel program already functioning in our hospitals, the manual will help us to evaluate the results. If we do not have a personnel program, it will guide us in establishing one on a sound basis.

First impressions are often lasting. Usually the first impression of our hospital on the patient, his relatives or friends is made by the appearance of our entrances, vestibules, elevators. If these are not well dusted and clean, if things are not in repair, the patient may think that the entire hospital is inefficiently operated. Hence our need for some knowledge of the essentials of good housekeeping. Maybe we have a good housekeeper. Possibly we are responsible for the housekeeping, with the aid of some hard working maintenance personnel. In any event we need some definite policies to guide us. Therefore attending one of the housekeeping institutes of the A.H.A. would be profitable in alerting us to the importance of good housekeeping in our hospitals.

We are not dietitians, chefs or cooks, but we are ultimately responsible for serving a well balanced diet of good, nutritious, palatable and attractive food to our patients. Possibly we cannot get a good dietitian. One will not come to our little, out-of-the-way hospital. We can, however, obtain assistance from dietetic specialists, share a dietitian with other hospitals in our area, or have a quarterly visit and assistance from a consulting dietitian.

We also have a responsibility for scientifically clean linens for our patients. We are not expected to know the details of laundry management, but we are responsible for having at least a knowledge of the general functions of the laundry. We may think that all laundry machinery is the same, or that all we need is a washer, an extractor, an ironer and a presser. We may need more or less equipment than we have. But what we need most of all is some knowledge of what is required for efficient laundry work; whether we have the right person as a laundry manager; the type of people who should work in the laundry, and many other data on which some of us are uninformed. It would do some of us good to attend a laundry institute.

ENGINEER NEEDS A FRIEND

At least a casual acquaintance with our engineering department is needed. If we can read an engineering department blueprint we have found a new, stimulating interest, and our engineer has found a sympathetic friend and listener.

Above all, a successful administrator should be active in organization work, such as hospital associations, nursing or business associations, and Blue Cross. In other words, we must give of ourselves for the good of humanity.

Let us unify all of our knowledge for the good of our patients and of all those with whom we come in contact. Let us not strive for paper credit, that is, a formal record of achievement through a maze of written reports that are sometimes unsubstantiated. Let us make of our hospitals institutions of spiritual and physical value for humanity where all are helped: patients, staff, personnel and ourselves. Capitalize on our own particular God-given and self-acquired capacities and personalities. Try to grasp the significance of present happenings. Analyze these happenings from the basis of past experiences, and the experiences of others in the same field. Study trends and issues in relation to society: politically, economically and scientifically. Keep alert, interested, generous with your mind and with your time for your patients, your personnel, your friends, your organizations. These are the essentials of successful administrative practices.

About People

Administrators


Dr. Morris Hinenburg

Dr. Morris Hinenburg has resigned as director of Jewish Hospital, Brooklyn, N.Y., to become medical and hospital consultant to the Federated Jewish Charities of New York. Dr. Hinenburg is a graduate of Yale University's School of Medicine. As soon as he completed his residency at Montefiore Hospital, New York City, he assumed the position of assistant director there and served for eight years before he moved to Jewish Hospital in 1936.

Mrs. Edna Mae Eckert has resigned her position as administrator of Lock Haven Hospital, Lock Haven, Pa. During her tenure there, Mrs. Eckert introduced several new features, including menu service for patients, job analysis, a traveling library and a traveling snack bar. She also modernized the hospital's medical record system.

Robert E. Nicholson, former industrialist and trustee of Frankford Hospital, Philadelphia, since 1943, has been named administrative head of the hospital to succeed **Elsie L. Miller.** Miss Miller joined the hospital as head nurse in 1910. During World War I she served overseas and was decorated for outstanding service. Following the war she returned to Frankford and was named superintendent in 1922. Mr. Nicholson was made managing director of the hospital a year ago in anticipation of Miss Miller's retirement. **Mrs. Beatrice Chase,** graduate of the University of Pennsylvania Hospital School of Nursing, has been named assistant to Mr. Nicholson.

Dr. Earle T. Norman has been appointed manager of the Veterans Administration Hospital, Amarillo, Tex. He will succeed **Dr. George Littell,** who was transferred recently to Wichita, Kan., as manager of the V. A. hospital there. Dr. Norman was chief medical officer at the regional office at San Antonio, Tex., before accepting a temporary assignment at the Veterans Administration Hospital, McKinney, Tex.

H. D. Adrain has been named business manager of the Methodist Hospital, Dallas, Tex.

Dr. Hubert P. Colton has been appointed superintendent of Essex County Sanatorium, Middleton, Mass., to fill the position left vacant by the resignation of **Dr. Olin S. Pettingill.** In 1937 Dr. Colton was appointed resident physician at the sanatorium and has served as assistant superintendent for the last three years.

Dr. Luis A. Angulo, assistant chief of the hospital division, Ministry of Health, Venezuela, has been appointed to a four-month administrative internship at the University of Illinois Research and Educational Hospitals. Dr. Angulo is in the United States on a two-year study visa observing the current methods and procedures of hospital operation.

Dr. Paul A. Hletko, chief medical officer of the Illinois State Department of Public Welfare, has been appointed executive officer of the Illinois Neuropsychiatric Institute, Chicago. He succeeds **Dr. Harry R. Hoffman,** who now is serving as director of the new mental hygiene section of the Chicago Department of Health.


C. A. Lamley

Carl A. Lamley has been appointed executive director of the Stormont-Vail Hospitals at Topeka, Kan., an organization that resulted from the merging of the Christ and Stormont hospitals of that city. Mr. Lamley has been administrator of the Highland Park Hospital, Highland Park, Ill., for the last three years. He is a graduate of the program in hospital administration at Northwestern University. Another Northwestern graduate, **Herbert Rodde,** has been appointed to the Highland Park Hospital position to succeed Mr. Lamley. Mr. Rodde was formerly assistant administrator of St. Luke's Hospital, Duluth, Minn.

Dr. Frank H. Barrett has been named acting administrator of Atlantic City Hospital, Atlantic City, N. J., succeeding **Nellie McGurran** who has been ill for several months. Dr. Barrett has been medical director of the Veterans Administration in New York. He was formerly head of Presbyterian Hospital, New York City, and medical director during the war of the Civilian Defense regional office for Delaware, New Jersey and New York.

Clara Coleman, R.N., has assumed the duties of administrator of The Dalles General Hospital, The Dalles, Ore., effective October 3. She replaces **John L. Sundberg** who resigned to accept a position as administrator of Caldwell Memorial Hospital, now under construction at Caldwell, Ida. Miss Coleman was administrator of Trumbull Memorial Hospital, Warren, Ohio, for eight and one-half years.

Walter C. Byers has accepted the position of administrator of the Jennie Stuart Memorial Hospital in Hopkinsville, Ky., succeeding **Mrs. Lucy A. Roper** who was killed in an automobile accident. Mr. Byers was assistant superintendent of Norton Memorial Infirmary, Louisville, for the last six years and is a member of the American College of Hospital Administrators and a personal member of the American Hospital Association.

Irving T. Howorth has been appointed assistant superintendent of St. John's Riverside Hospital, Yonkers, N.Y., it has been announced by **S. Chester Fazio,** superintendent. Mr. Howorth was formerly connected with the New York State Education Department in Albany, N.Y., and prior to that with the welfare department in White Plains, N.Y.

Harris B. Jones of Allegan, Mich., has been named administrator of Community Hospital, Kane, Pa., succeeding **Kenneth Brooks.** Mr. Brooks resigned to become administrator of Hayswood Hospital, Maysville, Ky. The new administrator has been working at Allegan under a W. K. Kellogg Foundation fellowship.

(Continued on Page 162.)

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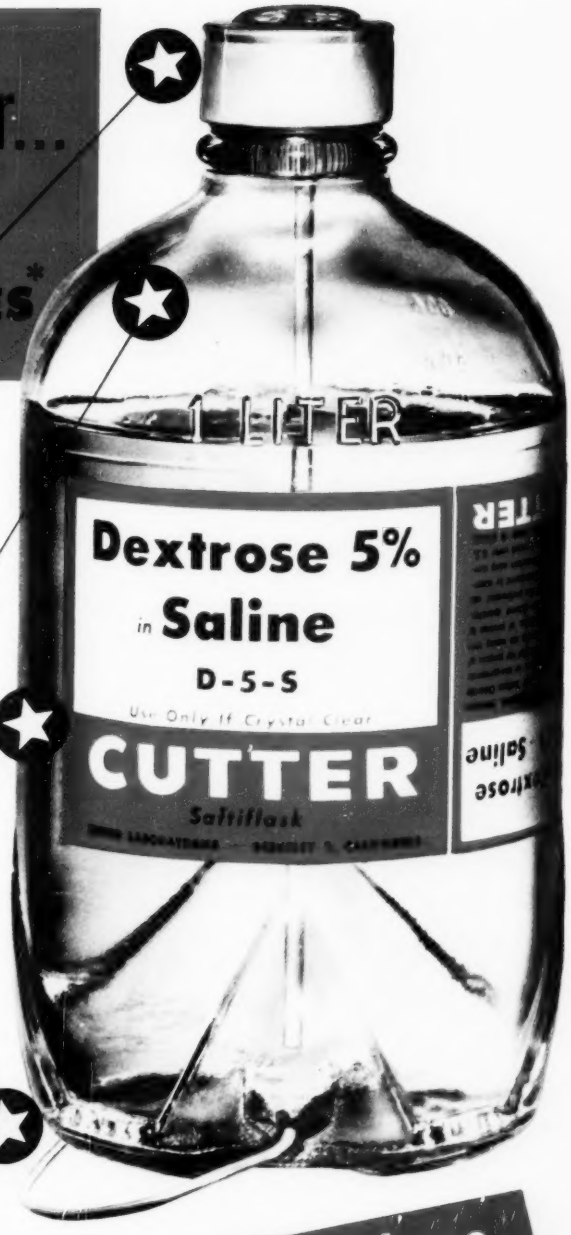

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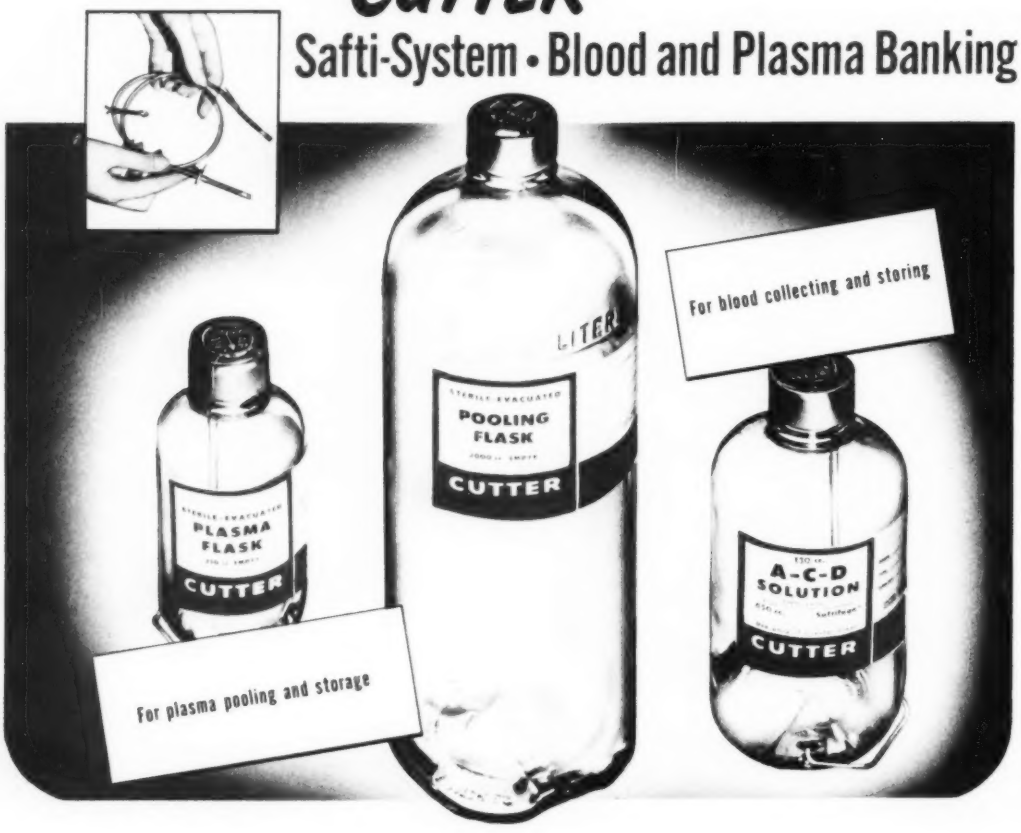


THE LIFE LINE OF THE HOSPITAL— the WOMEN'S AUXILIARY

ARTHUR FEIGENBAUM
Superintendent, Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y.

"SEMPER FIDELIS" can well be applied to the groups of women who, in time of war as well as in time of peace, play important rôles in the life of the American hospital. Many an administrator and many a member of the board of directors of hospitals have silently uttered prayers of thanks and relief when these ladies were on hand either to bring in monies for the maintenance of the institution and its special projects, or to fill in gaps created by vacancies and shortages in personnel.

FUNCTION IN VARIOUS WAYS

Ladies' auxiliaries function in various ways either inside the hospital itself or outside, and may be divided into different categories.

Group A concerns itself with raising monies by various methods, all such monies being turned in to the hospital's general fund for maintenance or enlargement of facilities.

Group B concerns itself with working directly with the patients.

Group C offers its services in the the hospital as volunteers in any capacity assigned, such as clerical workers, feeders and nurse's aides.

Group D raises monies for special projects conducted in the hospital or to be set aside for use in projects of its own choosing, or research problems, and may at times help in the department concerned on a voluntary basis.

The auxiliary setup of the Jewish Sanitarium and Hospital for Chronic Diseases of Brooklyn, N.Y., embraces all these groups. One of the largest hospitals in the world for chronic diseases, it opened its first wards in 1929 and since that date has been blessed by the fact that it has 12 auxiliaries and many affiliates, whose services have earned them the everlasting gratitude of its patients and its directors.

Most of these groups have adopted the names of areas in which the majority of the membership resides, such as the Flatbush Division, the Borough Park Division, the Bedford Division, the Williamsburgh Division. These groups cover the entire borough of Brooklyn and the hospital has been fortunate in receiving into its fold within the past few years two additional auxiliaries, one in Long Island and the other in Staten Island.

To avoid overlapping of functions and duplication, and to prevent the same individuals or business firms from being contacted too often, the hospital has adopted the policy of not accepting any more groups as auxiliaries from the areas covered.

Each group is represented at the meetings of the board of directors by its president and a representative, who have a vote in the election of the officers and directors of the hospital and in the formulating of its policies.

Each group works independently of the others—raising monies by its own methods—but all monies obtained must go to the hospital's general fund, and their books are annually inspected by the accountant of the hospital.

Periodically during the year representatives from all auxiliaries gather for exchange of ideas and formulation of plans for a concentration of combined efforts for the two annual functions of the hospital—a bazaar and an annual dinner, combined with a journal of advertisements.

Among the numerous activities that have proved successful are hotel luncheons and dinners, strawberry festivals, package parties, bridge parties, weekend trips to summer and winter resorts, and public dances, especially for the younger people.

Inspired by the efforts of their parents and the cause for which they work, many of the children and their friends have banded themselves into junior auxiliaries, adopting the names of the parent bodies. Their functions are conducted in a similar fashion to the parent group but a great deal of the money raised has come from public dances. All monies raised by the junior auxiliaries are turned over to the parent groups but as yet these junior auxiliaries have no vote at the board of directors' meetings.

Numerous groups of women's organizations interested in the activities of the hospital and its patients have been accepted as "Affiliates." These groups fall into two classifications.

Classification 1: These groups use the hospital name on their stationery in advertising all their functions, turn in all their monies to the hospital, and have the same rights as auxiliaries, but work principally for special projects, such as rheumatic cardiac children, occupational therapy, rehabilitation, cancer research, and many others.

WORK WITH PATIENTS

One in particular, the Occupational Therapy League, in addition to raising monies for this department, renders outstanding service as volunteers, working directly with patients day in and day out. Daily this group can be found in the hospital, working in the occupational therapy department, teaching arts and crafts and distributing books to ward patients.

Another group, known as the Mildred Forman League, has earmarked all monies raised to be used for maintenance of wards and the care of rheumatic cardiac children, and both these groups have been granted a vote at the meetings of the board

(*Continued on Page 92.*)

of directors. A group recently organized and known as the Miriam Klein Research Fund earmarks all monies raised by its various activities for cancer research.

Classification 2: This includes affiliates who work for many charitable causes, but contribute generously to the hospital's general fund for the purchase of equipment. A recent addition to the hospital has been an affiliate, which has agreed to allocate large sums of money for the care of inpatient and outpatient cerebral palsy cases. Affiliates in this group have no representation or vote in the hospital's policies.

One of the affiliates in this group, known as the Rose Rubel Society, has for many years brought concerts and theatrical shows into the hospital; this service plays a prominent rôle in the spreading of cheer and laughter among the patients, all of whom are long-time cases requiring mental uplift.

All the auxiliaries and affiliates, in addition to their generous contributions, on numerous occasions, particularly holidays, bring live entertainment and distribute refreshments to make the lot of the patient a happier one.

HONORED FOR SERVICE

To encourage activity and as an expression of appreciation, the hospital annually presents gold pins bearing the hospital name to those whose names have been submitted by the presidents of the auxiliaries. Those who have already received a pin have a diamond added at an annual "Testimonial Tea." In addition, each auxiliary selects from its own group the outstanding woman of the year, who will receive special recognition from the hospital.

The loyalty and support of these groups have made it possible for this hospital to expand and enlarge its facilities. The present capacity of 541 beds is to be increased to 800 this fall with the opening of an additional six-story building, numerous laboratories, a department of rehabilitation, and many clinics.

The life line that these ladies have thrown out, and which has been firmly grasped by the hospital, has earned the everlasting gratitude of its patients, the directors, and the administration, for its assistance for many years. Fortunate indeed is any hospital which can be, and is, the recipient of such invaluable aid.

VOLUNTEER ACTIVITIES

The Latest in Furnishings

Two newly decorated and furnished rooms at Women's and Children's Hospital, Chicago, are the gift of the Mary Thompson Auxiliary. Mrs. George W. Kralovec, auxiliary chairman, explains that the rooms have the latest in hospital furnishings and equipment. This includes new beds, which can be raised or lowered by the patient; a bedside table, which serves as a writing pad; a rack for books, and a complete cosmetics case with vanity mirror.

One room is on the maternity floor and is decorated in soft rose and blue; the other is on the third floor and is done in tints of green and pale yellow.

The Mary Thompson auxiliary, named for the pioneer woman doctor, founder of the Women's and Children's Hospital 84 years ago, has 50 members who have given their efforts to the institution for 15 years. The hospital has a new Benefit Guild, of which Mrs. Walter Krafft is chairman.

It Was Cooler Inside

Last summer the heat settled like a heavy wool blanket over most of the country. But a delightful oasis from heat and humidity was the Service Shop at Muhlenberg Hospital, Plainfield, N. J. The Woman's Auxiliary Board decided a year ago to install air conditioning in the shop, the cost being met entirely by profits from the shop.

Visitors and hospital personnel who dropped in for a little gift, a sandwich, a salad, or coffee had a few moments of delightful respite from the heat. Naturally business was brisk.

Flowers Capture Hearts

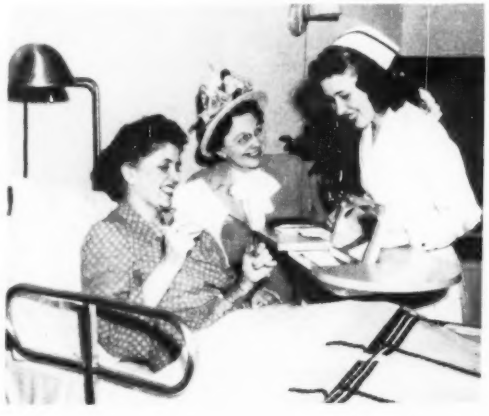
Winner of no ribbon, it did capture a number of hearts, among them that of a *New York Times* reporter who gave it more space than went to the prizewinners.

Conspicuous more by inexpertness than by beauty, this particular entry in a recent flower show of New York's Gramercy Park Association of the National Arts Club was made by four little girls and two little boys in the ward of the Bellevue Hospital Chest Clinic.

Set in a base of plain white plaster, as in casts, were tilted test tubes, as in labs, containing a few daffodils, iris and daisies, as in hospital bouquets. Said the *Times*:

"Unknown to the youngsters, their display had a meaning of far greater moment than even their joy. It marked the first time that youngsters from the ward have participated in a community project. It is a new step in the pilot project of a rehabilitation program for the children whose condition keeps them in the hospital sometimes as long as two years. It is the first 'social' link with the outside since 1922, when the ward was founded."

The clinic recreational director, Marion Tribble, had an idea that women's groups might encourage in their own hospital wards.



A patient basks in her elegant surroundings at Women's and Children's Hospital. At the left is Margaret Degenstein (patient); Carol Pauley (nurse) at right, and Mrs. George W. Kralovec, chairman of the auxiliaries.

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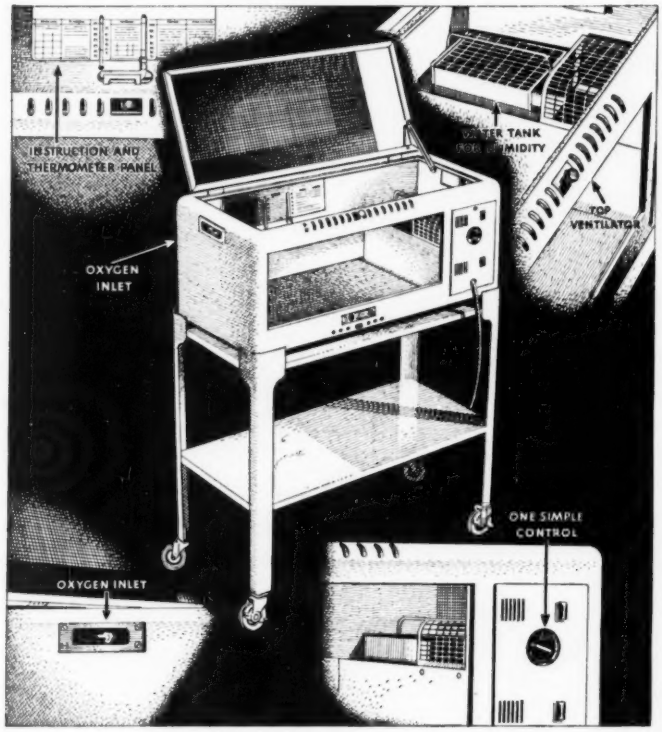

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THE HOSPITAL AND THE ALCOHOLIC

ROBERT V. SELIGER, M.D.
Chief Psychiatrist
The Neuropsychiatric Institute
Baltimore

WITH the feeling that—from the medical point of view—an acutely intoxicated individual is a sick person, general hospitals have been more and more "bothered" about this problem and increasingly bewildered and perplexed as to how to handle it. This has been especially so when the patient was the mate or relative of a member of the hospital staff, or of a prominent member of the community, or—as has frequently happened—was himself a prominent citizen. For these and other reasons, the administrator or superintendent of the general hospital has often been "put on the spot." One feels that this problem of what to do with the alcoholic will increasingly present itself owing to the fact that heavy social drinking and alcoholism are on the increase in these unstable times. Indeed, many thoughtful persons now feel that alcoholism today is America's unrecognized No. 1 emotional illness. Yet up to the present time, facilities for handling the various emotional and other problems associated with excessive drinking and facilities and technics for prompt and competent medical handling of the individual have been far from uniform.

FACTS ABOUT ALCOHOLICS

It may be helpful, before suggesting an over-all plan of treatment, including the rôle of the general hospital, to make a few statements about alcoholism and the alcoholic.

Statistics report approximately 800,000 known seriously sick alcoholics in this country and about 3,000,000 heavy social drinkers, or incipient alcoholics. But these are minimum statistics, based on hospital and police records. The actual figures are undoubtedly much higher. The accidents, deaths and other serious problems resulting from alcoholic incidents are numerous, and they are alarming. See your daily newspaper.

As to the alcoholic himself, he is a very sick person—sick in his thinking and behavior. When not drinking, he is likely to be unpredictable and mood-driven; and when drinking, his behavior is definitely "out of range." The alcoholic is also handled by alcohol to such an extent that his drinking interferes with the harmony of his life and with the following through of his important activities in life which comprise his working and personal responsibilities.

Alcoholism itself is a symptom of some, usually deep-seated, disturbance. It is like the tip of an iceberg. It may be symptomatic of any major or minor psychiatric reaction type. A large number of alcoholics, however, present no marked psychopathology; rather, they fall into a borderline group characterized chiefly by a "weak ego." One might say that these individuals have "cancer of the ego" and that, as with all cancers, early recognition and proper treatment are of the utmost importance.

Starting out on the premise that the ego is the core of human personality, one finds that these "weago" (weak ego) individuals lack or have not adequately developed one or more of the four essentials that are found in a strong and healthy ego, and which result in purposive and efficient conduct and living. (One must also remember that much of the content of the ego lies in the field of the unawareness.)

The four ego characteristics which this type of alcoholic lacks, to a great extent, or does not possess, are:

1. *Independence* (self-government).
2. *Freedom* (to think and act at a mature level).
3. *Power* (to manage situations and take responsibilities).
4. *Prestige* (assurance and feelings of adequacy).

In working with such a patient, we feel that, if his brain is still intact, it is possible for him to learn to understand the origin, the nature and needs of expression of the ego weakness which lies behind his alcoholism.

GUIDES FOR DAILY USE

But in addition to understanding himself better, the patient should be educated, and reeducated, about his personality and his alcohol problem by daily active use of the following guides:

1. He must be convinced *from his own experience* that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life.
2. He must be completely sincere in his desire to stop drinking once and for all.
3. He must recognize that the problem of drinking for him is not merely a problem of dissipation, but of a dangerous psychopathological reaction to a (for him) pernicious drug.
4. He must clearly understand that once a man has passed from normal to abnormal drinking, he can *never* learn to control drinking again.
5. He must come to understand that he has been trying to substitute alcoholic phantasy for real achievement in life, and that his effort has been hopeless and absurd.
6. He must recognize that giving up alcohol is his own personal problem, which *primarily* concerns himself alone.
7. He must be convinced that at all times and under all conditions alcohol produces for him not happiness but unhappiness.
8. He must come to understand that the motive behind his drinking has been some form of self-expression, some desire to gratify an immature, craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.
9. He must understand that alcoholic ancestry is an *excuse*, not a reason for abnormal drinking.
10. He must realize that any rea-

cough control

point by point

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sonably intelligent and sincere person, who is willing to make a sustained effort for a sufficient period of time, is capable of learning to live without alcohol.

11. He must fully resolve to tell the truth and the whole truth, without waiting to be asked, to the person who is trying to help him—and must be equally honest with himself.

12. He must avoid the small glass of wine—*i.e.* the *apparently* harmless lapse—with even more determination than the obvious slug of gin.

13. He must never be so foolish as to try to persuade himself that he can drink *beer*.

14. He must never be so childish as to offer temporary boredom as an excuse to himself for taking a drink.

15. He must disabuse his mind of any illusion about alcohol sharpening and polishing his wit and intellect.

16. He must learn to be tolerant of other people's mistakes, poor judgment and bad manners, without becoming emotionally disturbed.

17. He must learn to disregard the dumb advice—and often dumber questions—of relatives and friends, without becoming disturbed emotionally.

18. He must recognize alcoholic daydreaming—about past "good times," favorite bars, and so on — as a dangerous pastime, to be inhibited by thinking about his reasons for *not* drinking.

19. He must learn to withstand *success* as well as failure, since pleasant emotions as well as unpleasant ones can serve as "good" excuses for taking a drink.

20. He must learn to be especially on guard during periods of changes in his life that involve some emotion or nervous fatigue.

21. He must try to acquire a mature sense of values and learns to be controlled by his judgment instead of his emotions.

22. He must realize that in giving up drinking he should not regard himself as a hero or martyr, entitled to make unreasonable demands that his family give in to his every whim and wish.

23. He must beware of unconsciously projecting himself into the rôle of some character in a movie, book or play who handles liquor "like a gentleman," and of persuading himself that he can—and will—do likewise with equal impunity.

24. He must learn the importance of eating—since the best preventive for that tired nervous feeling which so often leads to taking a drink is *food*—and must carry chocolate bars or other candy with him at all times to eat between meals and whenever he gets restless, jittery or tired.

25. He must learn how to relax naturally, both mentally and physically, without the use of the narcotic action of alcohol.

26. He must learn to avoid needless hurry and resultant fatigue by concentrating on what he is doing rather than on what he is going to do next.

27. He must not neglect care of his physical health, which is an important part of his rehabilitation.

28. He must carefully follow a daily self-imposed schedule which, conscientiously carried out, aids in organizing a disciplined personality, developing new habits for old, and bringing out a new rhythm of living.

29. He must never relax his determination or become careless, lazy, indifferent or cocky in his efforts to eliminate his desire for alcohol.

30. He must not be discouraged by a feeling of discontent during the early stages of sobriety, but must turn this

feeling into incentive to action which will legitimately satisfy his desire for self-expression.

31. He must not drop his guard at any time, but especially not during the early period of his reorganization, when premature feelings of victory and elation often occur.

32. He must understand that, besides abstinence, his real goal is a contented and efficient life.

33. He must appreciate the seriousness of his reeducation, and regard it as the most important thing in his life.

34. He must realize that most people seeking psychological help for abnormal drinking are above average in intellectual endowment, and that, while drinking means failure, abstinence is likely to mean success.

35. He must never feel that any of these commandments is in any way inconsequential, or secondary to business, play or whatnot, and must conscientiously observe every one of them, day in and day out.

In the medical psychological approach it is also necessary by means of psychotherapy to have the individual develop inner peace so that he can live in the world, and in his world, without desiring or "needing" the socially accepted and easily available narcotic provided by any sort of alcoholic beverage.

This is finally accomplished by having the individual convince himself of the necessity of living automatically by and through the age-long enduring values of life, among which are:

1. Be a giver instead of a taker. (Be as unselfish as possible.)
2. Tolerance.
3. Humility.
4. A definite belief in the worthwhileness of life.
5. The actual return to religion.

Through this acquiring or regaining of the enduring values, the successful patient develops a way of life which will give him inner peace and enable him to live without experiencing more anxiety, tension, hostility or frustration than he can handle; and when this is solidly achieved, he will not consciously or unconsciously be dominated to start drinking again.

One might mention here that some alcoholics have stopped drinking by themselves. Others have been helped by religious groups, lay groups, and lay-and-religious groups. Even the old "Keeley Cure" helped many an alcoholic—and some now recommend a conditioning or aversion treatment without psychotherapy, while others, with deeper interest, use this method in order to get a beach-head on the patient and then follow up with psychotherapy.

As a result of personal discussions and conversations with other therapists, I feel that, except in rare instances, deep, lengthy psychoanalysis alone, hypnosis alone, hypnoanalysis alone, narcoanalysis alone, or the assaultive therapies alone, such as chemical, drug or electric shock, or various types of lobotomy, are not helpful in the treatment of alcoholism. Generally speaking, especially trained psychiatrists are needed; and each alcoholic patient should be carefully examined and treated on an individual basis, in the same way as are cancerous and tuberculous patients.

As to the problem of what to do with the acutely intoxicated patient, he can be properly cared for in the accident room of the general hospital and detoxified by the following method:

After a short physical and neurological examination has been made, the patient is placed on a couch, given 1-2

grains phenobarbital and 3 grains sodium dilantin (as an anticonvulsant). At the same time the arm is prepared for immediate intravenous injection of from 1000 to 2000 cc. of 10 per cent dextrose in normal salt solution (isotonic solution of sodium chloride), which can be obtained from many hospital supply companies. One removes the sealing material, inserts the tube of the intravenous needle set, which can be purchased from such companies, and the drip intravenous flow is then started. As this goes on, 100,000 to 200,000 units of thiamin

hydrochloride (vitamin B_1) and 25 units of insulin are introduced into the tubing. One and a half hours later, another dose of phenobarbital and sodium dilantin is given; another, two hours later; and a third dose about three hours later. No alcoholic beverage of any kind is given and all drinking of alcoholic beverages is immediately stopped. Candy and heavily sugared orange juice should be available if mild insulin shock reactions occur.

This treatment will clear up uncomplicated cases of acute intoxication or D.T.'s in individuals under 55 in about 10 hours. In some instances it may be wise to administer another 1000 cc. intravenously with insulin and vitamin B_1 on the following day, and for several days after the first visit the patient should be kept on phenobarbital grain 1 and sodium dilantin grains 3, t.i.d. and q.n. and from 50,000 to 100,000 units of vitamin B_1 intramuscularly.

START PSYCHIATRIC STUDY

After detoxification in the accident department and after a careful physical examination, including any indicated special tests, the alcoholic patient should be studied in the psychiatric outpatient department of the hospital or at a competent mental health clinic in the vicinity. Thorough study includes the usual psychiatric surveys, psychological testing by means of the Rorschach, the Thematic Apperception Test, Kohs Blocks, Shipley-Hartford Deterioration Test, the Wechsler-Bellevue Adult Intelligence Measurement Scale, graphological and drawing specimens, and a neurological examination. Based on a formulation of all the resulting findings, one can then recommend treatment procedures, including placement. Some alcoholics may be referred to a psychiatric outpatient clinic, or to a mental health clinic. Others may be referred to private psychiatric hospitals, state psychiatric hospitals, social service, religious or competent lay groups.

In conclusion, I would like to state:

1. Alcoholics are sick people.
2. They should not be treated in general hospitals.
3. All alcoholics cannot be helped.
4. All alcoholics are not hopeless.
5. Acutely intoxicated alcoholics should be treated in an accident room setup of a general hospital.
6. Chronic alcoholics should be admitted to general hospitals for physical examinations and tests only.
7. Some chronic alcoholics may be treated in the psychiatric outpatient department of the general hospital, or at a near-by mental health clinic.
8. Alcoholism today is America's No. 1 unrecognized emotional illness.

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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

SYNTHETIC VITAMIN A

THE three most important sources of vitamin A in the past have been first, some yellow carotenoid pigments from plants (such as carrots) which may be converted in man to vitamin A; second, dairy and poultry products such as eggs, milk and butter, and, third, certain species of fish liver. The last has in the past been the only source of sufficiently high concentrations of vitamin A to permit the extraction of vitamin A on a commercial scale.

The disadvantages of vitamin A derived from fish liver oil are as follows: Considerable deterioration in potency occurs which not only creates difficulties in the pharmaceutical manufacture of preparations containing vitamin A, but also tends to make such products more expensive to the consumer. Fish liver oil is not well tolerated by allergic individuals, and most patients, even if they are not allergic, object to the fishy eructations which almost invariably follow the ingestion of fish liver oil. Fish liver contains vitamin D as well as vitamin A, which makes it impossible to give large doses of vitamin A when an increase in vitamin D intake is contraindicated. The extraction of pure vitamin A from fish liver has been such a difficult task that much basic work in the physiology of and therapy with vitamin A still remains to be done.

In approximately the last ten years a number of syntheses of vitamin A has been reported, but until recently none was sufficiently practical to give sufficiently high economic yield for commercial production. The successful large scale production of synthetic vitamin A has been accomplished in at least one laboratory.

CHEMISTRY

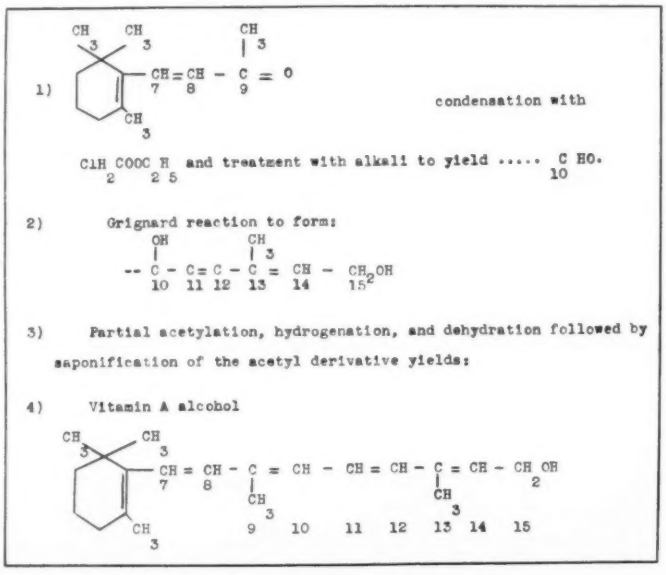
The synthesis of vitamin A by Isler, Huber, Ronco and Kofler (Helvetica Chimica Acta **30**: 1911, 1947) may be described in the abbreviated form shown in the accompanying illustration. Chemical and physical tests show this synthetic product to have all the required characteristics of natural vitamin A. The potency of the pure chemical is 3,000,000 units per gram.

SYNTHETIC VITAMIN A IN NUTRITION

Synthetic vitamin A has been used by Jeans, Stearns and Knapp at the State University of Iowa as the only form of vitamin A in the diet of infants. Studies of absorption, excretion and blood levels of vitamin A carried out for more than a year have demonstrated that synthetic vitamin A is an adequate replacement for natural vitamin A in growing children. The aqueous dispersion of vitamin A palmitate is well tolerated and is rapidly absorbed. The palmitate ester of vitamin A is apparently more stable in aqueous dispersion than the acetate and alcohol of vitamin A.

While standards for minimum daily requirements of vitamin A have been established for man, there is some reason for believing that these values may be subject to change. The methods for determining vitamin A leave much to be desired. For example, no entirely satisfactory method exists for the determination of the vitamin A content of feces. This obviously makes it impossible to determine precisely the amount of vitamin A that is absorbed or destroyed in the intestine. The same criticism also applies to the figures commonly assigned for the vitamin A values of many foods. The only food whose vitamin A content is

SYNTHESIS OF VITAMIN A



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beyond question is oleomargarine to which definite known quantities of vitamin A have been added.

A definite need exists for the clarification of the interpretation to be placed on blood levels of vitamin A. The following questions, for example, require further study. While we do have data on *normal* blood levels of vitamin A, what are the *optimal* blood values? Does this vary with age and with conditions such as pregnancy and febrile disease? Are absorption curves (similar to glucose tolerance tests) of more importance than blood values *per se?*

THERAPY

The following signs have been generally accepted as suggesting deficiencies of vitamin A.

Xerosis of the conjunctiva: Thickening with loss of transparency, so that only the more superficial vessels of the bulbar conjunctiva are clearly seen, associated with more or less yellow pigmentation, especially along the horizontal meridian of the eyeball; infrequently associated with small foamlike plaques called Bitot's spots and vascularization of the cornea.

Papular eruptions associated with pilosebaceous follicles: A grater-like feel to the skin, which in early stages resembles gooseflesh but when more fully developed presents the picture of keratosis pilaris. The extensor surfaces of the arms and thighs and the flexor surfaces of the legs are primarily affected.

Xerosis or asteatosis of the skin: Dryness, scaliness and crinkling, in extreme cases resembling alligator skin. In early stages the condition is associated with keratosis pilaris but this persists and extends after the follicles have disappeared, the body hairs being broken and later lost. All parts of the body are involved, but the skin of the extremities, particularly of the legs, is more severely affected than the skin of the head and the trunk.

Follicular conjunctivitis: Hypertrophy of the follicles, particularly of the inferior portions of the conjunctivae.

Night blindness: This is due to some failure in the formation of visual purple (rhodopsin) in the rods of the retina which cells are necessary for the best vision in dim light. This deficiency is conspicuous only in advanced severe cases.

Keratomalacia: Thickening with subsequent ulceration and necrosis of the cornea: present only in most severe

and advanced forms of deficiency.

It is thus apparent that insofar as we now know the functions of vitamin A it is primarily concerned with biochemical normality of the epithelial cells of the body.

A number of other clinical conditions have been reported to be associated with vitamin A deficiency; however there is some question as to the validity of these observations. Among such conditions are urinary lithiasis and degenerative changes in the nervous system.

Vitamin A has also been used as therapy in conditions not obviously due to deficiency, for example, hyperthyroidism, acne, and certain allergic disorders in children.

One of the reasons for the lack of definition of indications for vitamin A therapy is the paucity of reports in which blood levels of vitamin A are correlated with clinical symptoms. A notable exception is the important work of Kirk and Chieffi. These investigators studied 106 elderly patients and reported a significant correlation between low values for blood vitamin A and hyperkeratosis of the skin follicles and localized conjunctival thickening. Dryness of the skin and blepharoconjunctivitis was also more frequent in subjects with vitamin A deficiency. They found no correlation between the vitamin A levels and the number of epithelial and keratinized cells in the urine.

The impaired absorption of fat in such conditions as celiac disease makes the administration of more readily utilized forms of the fat-soluble vitamins important if deficiency is to be avoided. For this reason, an aqueous dispersion of vitamin A palmitate is recommended in any condition of the gastrointestinal tract that may interfere with fat absorption. This also holds true in any febrile disease, since it has been demonstrated that fever interferes with the absorption of vitamin A.

DOSAGE

The minimum recommended daily requirement of vitamin A for adults is about 4000 units per day. Some authors suggest about 6000 to 8000 for a growing child and about 5000 during pregnancy and lactation. These figures may be low for reasons previously described and because it has been shown, for example, by Friderichsen and Edmund that children under 2 years of age differ in their ability to utilize vitamin A from various food sources. It would, therefore, seem advisable to supplement the normal diet with adequate amounts of readily absorbable vitamin A.

The dose of vitamin A used in therapy varies from 75,000 to 200,000 units daily in divided doses.

TOXICITY

Carotene may accumulate in the skin in sufficient concentration to cause a deep yellow coloration known as xanthosis cutis, when large amounts of vegetables containing carotene are ingested and in certain metabolic disorders, especially diabetes. No harmful effects have been noted of this condition; however it may be mistaken for jaundice.

The literature on the toxicity of vitamin A is confusing in that most of the reports are on animals which generally received both vitamins A and D. There are insufficient data on man using large doses of vitamin A *per se*. There is evidence, however, that in growing children, vitamin A in excessive doses over a period of time will impair both growth and bone structure and may result in edema of the hands and feet.—M. J. SCHIFFRIN, PH.D.

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CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Preventive Medicine

The July 1949 issue of the "Annals of Internal Medicine" records Dr. Stanhope Bayne-Jones' Bruce Memorial Lecture on preventive medicine, delivered before the thirtieth annual session of the American College of Physicians.

The author discusses the reasons for the development of preventive medicine. Among these were the discovery of the bacteriology of disease. Such discoveries had a tremendous effect on hospitals in that they neutralized "fatal hospitalism" and made hospitals safe, and the demand for hospital care increased tremendously.

The author defines hospitals and preventive medicine as follows: Whatever the type of hospital, all have "the characteristic of being organizations with physical facilities and associated trained staffs for the care of the sick in bed in their inpatient service, or on their feet, in the outpatient department. Among their functions are service, education and research. In the social order they belong to their communities." The author offers a number of definitions for preventive medicine, among them being General Simmons' definition, which is "the sum total of all those services required to prevent disease and keep well people well." The author continues by saying that there is no real dividing line between curative and preventive medicine, and therefore it is only natural that the hospital should be a center for both. Among the general considerations necessary for this purpose are:

1. Attitudes: It must be realized that the hospital is a social institution and must function as a center of medical care and health services. The author feels that more attention should be paid to this concept.

2. Facilities, equipment and construction: Hospitals should be so constructed that the enlarged conception of its functions can be realized, especially in outpatient departments, doctors' offices, laboratories, space for occupational therapy and rehabilitation, and nursing functions.

3. Education: A greater educational emphasis should be placed on preventive medicine, the significance of group practice, the education of patients in carrying out instructions for their own good; health education, and an appreciation of the social science aspects of medicine.

4. Research: Research in every aspect of preventive medicine in every department of the hospital should be encouraged.

5. Relationships: The relationship of the hospital to systems of medical care is becoming more and more obvious. The more systems we have providing comprehensive medical care, the more will preventive medicine become important in the hospital's relations with these plans.

The author suggests 17 special activities, facilities and arrangements in a hospital which has become a center of preventive medicine. These are:

1. Diagnostic clinics for people of all economic levels.
2. Consultation services for all.
3. Expansion of hospital connections with the physicians of the community.
4. Periodic health examinations for the well, and early detection of chronic diseases.
5. Child welfare and development clinics including nursery schools.

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Hyperthyroid
Menopause

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm
Pylorospasm
Spasm of biliary tract
Spasm of colon
Peptic ulcer
Colitis
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.

Irritability Associated With Infections

Restlessness and Irritability With Pain

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

PEDIATRIC
Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery
Preoperative Sedation

6. Prenatal and postnatal clinics.
7. Preventive dentistry and oral hygiene.
8. Health services for personnel.
9. Interest in industrial medicine by examination of plant personnel at industrial plants and the recognition of industrial hazards.
10. Follow-up clinics.
11. Treatment and prevention of communicable diseases by education, by maintaining services for treatment, by immunization, and by integrating the communicable disease problem with the activities of the hospital.
12. Nutritional advice and supervision.
13. An enlarged social service program well integrated into the medical picture.
14. Coordination of hospital with public health and visiting nurse services.
15. Development of group practice either in the hospital or in relation to medical groups in the community.
16. Development of programs for convalescent and home care centered in the hospital and motivated by a sense of continuing service from the home to the hospital and the hospital to the home.
17. A further development of record keeping and mortality and morbidity statistics so that the hospital may serve as a center of epidemiology and control of disease.

The author is aware of the fact that this outline of activities implies the involvement of a hospital in further financial expenses and raises the question as to how far a hospital can go in participating in a practical plan for medical care. He does not attempt to answer these questions but feels that in order for the hospital to serve as a center of preventive medicine it must become involved in the activities he has outlined. A good bibliography is appended.—IRVING GOTTSEGEN.

Good Clinical Department

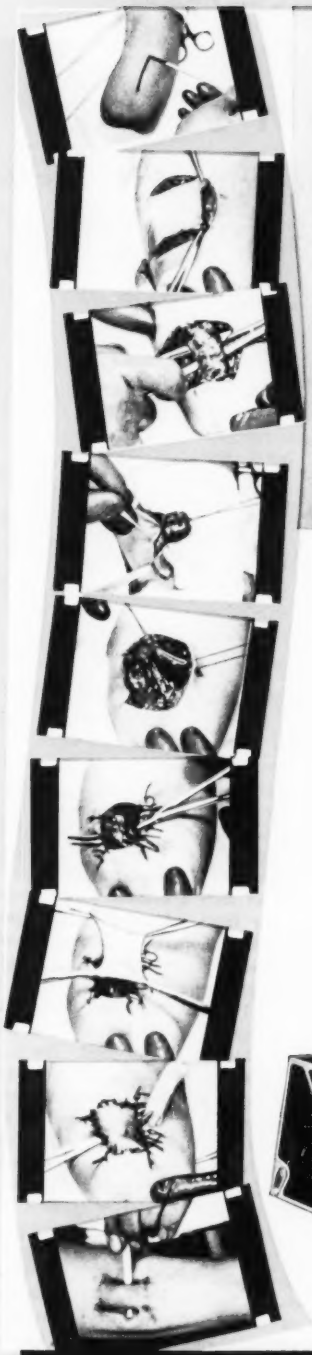
Many of the answers to the question "What makes a good clinical department?" may be found in the August 1949 *American Journal of Obstetrics and Gynecology* under the title "The Organization and Relationships of a Department of Obstetrics and Gynecology" by William F. Bengart, M.D.

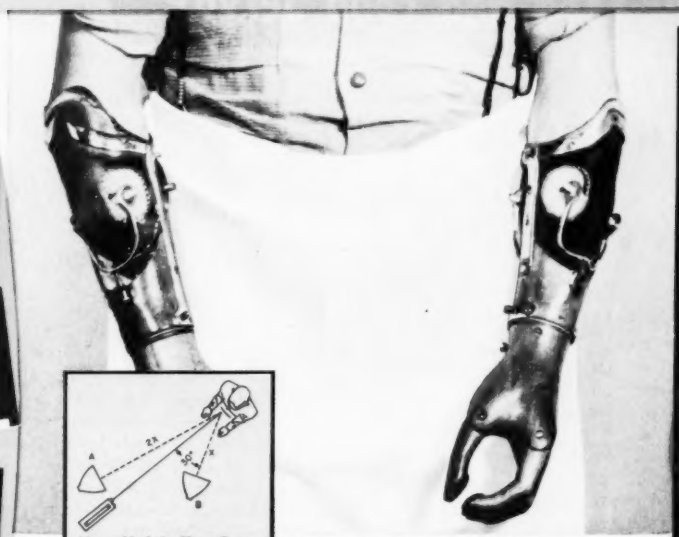
The author firmly believes that the combined department of obstetrics and gynecology should be directed by a "full-time seasoned clinician with a flair for teaching and an appreciation of research." In order to combat the "ivory tower" tendency and to provide an adequate income the chief should be allowed to see a certain number of private patients and to pocket the proceeds.

The main function of a visiting staff is to instruct, the author continues, and not to rotate control of the service. To fulfill this obligation staff members must be men of wide experience and be years beyond the training level.

To the resident staff belongs most of the clinical material, the author believes, and while there should be some supervision, the senior resident "must be permitted to exercise judgment and perform operative procedures without the threatening nuisance of a hovering staff man." The resident staff should do most of the teaching of students.

The active clinical department should carry on teaching at all levels with special attention to the general practioners within the hospital's area. Research too is important, although the author doubts the value of lower animal research to his particular specialty. —JOHN D. THOMPSON.





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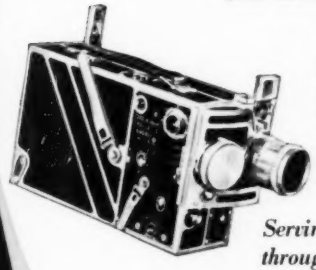

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THE SUCCESS OF A FOOD COST SYSTEM

depends upon the use that is made of it

HENRY W. ESPERSEN
Horwath and Horwath
Chicago

THERE are many approaches to food control, some simple and others quite involved, depending largely on the practical experience behind the individual or firm that installs it and the circumstances and conditions encountered in each particular operation.

However, it is not alone the method, or the system, of food control that gets the desired results but, to a large degree, the use to which the information supplied by such a system is put. Without the sincere interest of the head dietitian and the chef in the figures and trends indicated in the food reports, the time and effort put into their compilation are largely lost. In the final analysis it is they who are responsible if the cost is too high, and who deserve the credit for any improvements made. Without the aid of purchasing specifications, portion cost studies, food cost reports, and comparative data, those responsible for the policies and the details of operation in the dietary department are forced to grope blindly for the causes of unsatisfactory results. Without such information, the situation usually becomes progressively worse until the losses mount to prohibitive proportions.

FORM WITHOUT SUBSTANCE

Many consider food control as unnecessary clerical work which probably adds more to the pay roll than it could be expected to save. In some instances, where such work has been improperly outlined and delegated to an inexperienced clerk, this point of view is probably well founded. However, the fact is that in the majority of such cases there had been no food control at all, in the true meaning of the term, but merely a skeleton form of report which the administrator hoped would, in itself, perform the miracle of lowering the food cost per meal.

Real food control has a much broader scope than the rendering of reports on costs. It extends from the purchasing of food, on through its proper receiving, storing, issuing, preparation and service. Weaknesses in any one or more of these steps spell unsatisfactory results in the operations. Therefore, the immediate questions that an experienced food cost accountant would want to satisfy himself on would be:

1. Are proper specifications set up for buying?
2. Is buying done on a competitive price basis?
3. Are all deliveries properly checked for quantity and quality?
4. Are proper receiving records maintained?
5. Are the credits for returned merchandise properly followed through?
6. Is the storeroom properly controlled?
7. Are inventories taken regularly, calculated correctly, and properly reconciled?
8. Are the coolers kept at proper temperatures?
9. Is meat cutting done efficiently?
10. Are portion sizes properly established and consistently maintained?
11. What are the portion costs?
12. What is the cost per meal?

The points enumerated are not, by any means, all that must be watched in the operation of a food department; there still remain the questions of proper cooking temperatures, overproduction, overbuying and the insidious problem of pilferage.

As applied to a hospital, the purpose of food cost accounting is to assist management in providing meals to patients, staff, nurses and employes at the lowest possible cost consistent with the administration's policy in regard to the quality and quantity of food to be served. Also within the province of food cost accounting are any measures which make it possible to supply better meals without increasing the cost.

It cannot be stressed too strongly that food control, when properly administered, never attempts to achieve results by skimping on the quality of the food or the size of the portions. It does not take a scientifically cost-minded person to reduce costs by lowering quality or quantity; any quack can do that.

ACCURATE COMPUTATION NEEDED

Food cost accounting for a hospital revolves around the accurate daily computation of the food cost per meal served. To arrive at this, if all that were necessary were figures on the total cost of food consumed, divided by the total number of meals served, the problem would be a simple one. But such a blanket figure would be far from informative as a guide in preparing budgets, arriving at policies and appraising the efficiency of the dietary operations.

For one thing, as we all know, everyone in the hospital does not get the same kind of meal. The cost, for instance, of a meal for a private patient on a special diet may be twice the cost of a meal served to a ward patient who is not on a special diet. Taken into account, also, must be the foods consumed in between-meal nourishment and infant feeding, as well as the different classes of meals served in the personnel dining rooms, which are usually divided into those for general employes, for nurses and for doctors. Thus, to be of any value, the food control system must be thorough enough to show the accurate food cost

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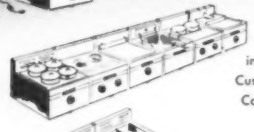

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for each type of meal served, rather than just an indiscriminate, over-all average.

The importance of properly checking and recording deliveries is too often lost sight of, with the result that improper quality and incorrect quantities are often accepted. The authority to receive and accept merchandise should be strictly delegated to a responsible person who knows quality and is familiar with the established specifications. He should be authorized to refuse any commodity not up to standard and when in doubt should call the chef or dietitian to pass judgment.

A receiving record should be maintained which lists the details of all merchandise delivered, including the name of the vendor, the quantity of each item received, the unit price, and the price charged for the quantity delivered. This form should be so ruled that the clerk can show on it the distribution of the purchases as to food charged to the storeroom, food charged direct to the kitchen, and items charged to sundry supplies.

DEPENDS UPON LAYOUT

The extent of the direct charges to the kitchen depends largely upon the physical layout and the location of the perishable goods coolers. Obviously, if all fresh meats, vegetables, fruit and dairy products must be placed in coolers in the kitchen, where the kitchen employes can help themselves to their requirements, there is no alternative but to charge them direct. Experience has proved that maintaining a dependable record of withdrawals under such circumstances is hopeless. Therefore, it is best to keep the direct charges at the lowest practicable point; in fact, to have none at all, if possible. The fewer direct charges there are, the more rigid the control can be and the more accurate the daily figures on costs.

Requisition forms for the issuing of merchandise from the storeroom are a "must." And I do not mean a running requisition which the storeroom man keeps on his desk and adds to as he issues goods on verbal or telephoned orders. Each requisition should be made out by the person requiring the goods and should be countersigned by someone in authority. Too often, the importance of this method is overlooked.

The storeroom setup that I have found most dependable requires the receiving clerk to write with heavy crayon the price per dozen on each case of merchandise received. As the cases are unpacked, the price per unit is written on each container as it is placed on the shelves. Thus, when anything is issued, the cost price can immediately be written on the requisition. This eliminates the need for keeping a price book, and has the further advantage that there is never any doubt that the actual purchase price is charged, regardless of fluctuations in the market price. This method is simple, direct and effective. Where meats and perishables are handled through the storeroom, the same system may be applied by attaching tags to the merchandise with wire hooks. As this merchandise is issued, the tags are removed and the costs are entered from them to the requisitions.

Regarding the control of merchandise stock, we often find that perpetual inventory records are maintained on food stores. But in my many years of experience, I have seen few instances in which the benefits of this sort of record justified the time and effort put into it. Instead, an efficient stock control can be maintained by taking an accurate monthly physical inventory and reconciling it to the figure obtained by the formula: beginning inventory, plus purchases, less withdrawals.

The form used for the recording of the monthly physical inventories is important. We prefer a bound book, ruled to accommodate 12 consecutive inventories with only one writing of the items. In setting up this book, the stock items should first be classified into a number of representative commodity groups, and the items of each group entered in the book under their respective headings in alphabetical order. Spaces should be left between the entries for new items which may be purchased from time to time during the year. Index tabs, attached to the edge of the first page of each grouping, make it easy to find any listing quickly.

In connection with inventories, one should not fail to remember the importance of the goods in process, generally referred to as the "producing" or "kitchen" inventory. This refers both to merchandise which has been charged out of the storeroom and the direct charges, and this inventory should be recorded separately from the storeroom inventory.

The taking of producing inventories is essential because the value of goods in process can have a decided effect on the cost of food in any given period. This is especially true when there are heavy direct charges. Disregard of the producing inventories can only result in inconsistent month-to-month average meal costs, thus reducing the accuracy of any cost system.

The food control procedure which I recommend requires the keeping of four special forms in addition to the records for purchasing, receiving, issuing and inventories already mentioned.

These forms are: the "Distribution of Daily Purchases"; the "Distribution of Requisitions and Transfers"; the "Summary of Purchases and Issues to Date," and the "Daily Food Report."

Let us consider first Form 1, the "Distribution of Daily Purchases." This is a 13 column sheet designed for the purpose of segregating the food purchases into a number of representative groups.

The divisions recommended are:

Meats
Poultry
Seafood
Vegetables and Fruits
Eggs
Butter
Milk and Cream
Ice Cream
Cheese
Bread and Pastry
Coffee, Tea and Cocoa
Staples and Groceries

This daily distribution of purchases should be recorded directly from the invoices. The total, of course, should be balanced with the total food purchases each day.

The record thus established shows the ratio of the cost for each classification of food purchased to the total food purchases, and also enables a detailed reconciliation of monthly inventories.

Form 2, the "Distribution of Requisitions and Transfers," provides for the recording of storeroom issues and of transfers according to the production units which received or transferred the items and the classes of meals and dining rooms in which they were used. The meal and dining room headings on this form vary, of course, in different hospitals. A fairly typical setup carries the following captions:

Private Patients
Semiprivate Patients
Ward Patients
Special Diet Patients

Doctors' and Executives' Dining Room
Nurses' Cafeteria
Employes' Cafeteria
Kosher Kitchen
Main Kitchen
Bakeshop

To obtain a breakdown of cost through such a division, accurate transfer records must be provided. For the patients' meals, you have the meal orders from the private halls, the diet lists, and the diet orders from the floors. These, then, can serve as transfer records for the different groups of patients' meals. As for the food issued or transferred to the personnel dining rooms, the supervisors in charge of such rooms should be required to requisition any food — prepared or otherwise—that they obtain.

In order to cost these transfers correctly, so as to credit the main kitchen and bakeshop and charge the divisions to which the food is sent, cost tests of finished products are necessary. These are the most difficult part of the entire project and, incidentally, the most important. Unless these transfer costs are properly established and kept up to date in accordance with changing market prices, the resultant meal costs will not be correct. And incorrect records are, of course, worse than none at all. By misrepresenting the actual cost picture, they may give a false sense of security, where in reality a serious cost condition exists.

After the transfer records have been priced, the amounts are posted on this Form 2, that is, the merchandise is charged against the divisions which have received it and credited to the departments which produced it.

Form 3, the "Summary of Purchases and Issues to Date," is a cumulative record of the data assembled on Forms 1 and 2, and is maintained as a control. This form shows the day's and the cumulative-to-date figures for purchases and issues, broken down into the same commodity groupings as in Form 1. Form 3 also provides a column on the extreme right for the to-date calculation of the ratios to the total issues of the costs in the various food groups. A comparison of these ratios with previous records reveals any undue rise in the cost of any group.

Form 4, the "Daily Food Cost Report," is a summary, for the day and for the month to date, of the food operations according to types of meals and dining rooms. This form shows both the cost of food and the number of meals served in each category, as well as the respective costs per meal for the day and for the month to date.

The day's costs are copied from Form 2 and are then accumulated to date.

The number of meals served to patients should be obtained from a daily census report sent to the chief dietitian's office from the admitting office.

The personnel meal count should be obtained from reports submitted daily by the respective units, each of which should keep accurate count of the number of meals served.

This method of food cost accounting shows the relation of the meals served in the various divisions to the total number of meals, and also the cost of the private patient's meal in comparison with the per meal cost in other divisions. Such data are essential in judging the efficiency of the dietary department. A further advantage of the system is that the information it provides is available daily. This means that operational inconsistencies or faults are promptly revealed, and, therefore, can be corrected without delay that is often costly.

To carry out this system in its entirety requires a full-time, efficient cost clerk, with sufficient knowledge of food operations to conduct all of the required cost tests and compile the other data. However, the system can be modified to show daily only the purchases and costs by food classifications and the total cost per meal. The "Distribution of Requisitions and Transfers" would then not be needed, and the "Summary of Purchases and Issues to Date" could serve also as the "Daily Food Report," thus eliminating the keeping of that record separately. Such a modified system would, of course, sacrifice much valuable information, but it would, at least, be a long step in the direction of the control of food costs. While it is a compromise, the shortened method is certainly better than no method at all for reporting food costs daily.

If food cost accounting is to serve as a tool in the control of food costs, it must be on a daily basis. Otherwise, excessive costs, and the reasons for them, may be detected only after the inefficiencies have already cost the hospital an appreciable amount of money.

Condensed from a paper presented before the Chicago Hospital Buyers' Association, 1949.

Menus for December 1949

Grace F. Headrick
Community Hospital
Beloit, Kan.

1
Half Grapefruit
Omelet, Toast
•
Fruit Cup
Rolled Beef Roast, Gravy
Mashed Potatoes
Escalloped Tomatoes
Head Lettuce Salad
1000 Island Dressing
Butterscotch Ice Cream
•
Vegetable Soup, Wafers
Hot Beef Sandwich
Buttered Green Beans
Waldorf Salad
Royal Anne Cherries
Angel Food Cake

2
Prunes
Boiled Eggs, Toast
•
Clear Broth
Salmon Croquettes
Browned Potatoes
Baked Squash
Cranberry and Orange Salad
Peach Cobbler
•
Cream of Asparagus Soup
Ham and Noodle Ring
Candied Sweet Potatoes
Harvard Beets
Raw Vegetable Salad
Plums, Sugar Cookies

3
Applesauce
Sausage, Toast
•
Cream of Spinach Soup
Fried Liver With Bacon
Parslied Potatoes
Buttered Brussels Sprouts
Molded Spiced Grape Salad With Mayonnaise
Apricot Cream Pudding
•
Tomato Bouillon
Macaroni and Cheese
Buttered Peas
Orange Sections With Olives, French Dressing
Sliced Peaches, Wafers

4
Grapefruit
Bacon, Sweet Rolls
•
Cream of Corn Soup
Baked Chicken, Dressing, Giblet Gravy
Mashed Potatoes
Creamed Cauliflower
Cranberry Jelly
Pineapple Sherbet, Cake
•
Vegetable Beef Soup
Scrambled Eggs
Buttered Green Beans
Cottage Cheese and Beet Salad
Apricots

5
Stewed Raisins
Poached Egg, Toast
•
Creole Soup
Baked Ham
Sliced Baked Yams With Orange Slices
Buttered Asparagus
Lettuce, Fr. Dressing
Apple Strudel
•
Cream of Corn Soup
Rice Nests With Meat Balls, Mushroom Sauce
Baked Tomatoes
Gingerale Pear Salad
Baked Apple, Cookies

6
Pineapple and Banana
Coffee Cake
•
Mutton Broth With Barley
Swiss Steak, Gravy
Mashed Potatoes
Buttered Wax Beans
Combination Vegetable Salad
Cherry Tarts
•
Tomato Bouillon,
Cheese Crackers
Salmon and Corn Soufflé
Buttered Carots
Fruit Gelatin Salad
Green Gage Plums, Wafers

7
Stewed Apples
Bacon, Toast
•
Tomato Bisque
Roast Leg of Lamb, Mint Sauce
Baked Potatoes
Harvard Beets
Mixed Vegetable Salad
Lemon Ice, Fruit Cookies
•
Cream of Celery Soup
Spaghetti and Tomatoes Succotash
Chicken in Gelatin Mold With Strips of Pimiento, Sliced Hard Cooked Eggs
Peaches

8
Prunes
Scrambled Eggs
•
Corn Soup
Meat Loaf With Tomato Sauce
Creamed Potatoes
Buttered Wax Beans
Pineapple and Carrot Salad
Raisin Pudding
•
Cream of Pea Soup
Spinach Loaf With Cream Sauce
Baked Squash
Veal and Celery Salad, Dressing
Apricots, Angel Cake

9
Orange in Baskets
Milk Toast
•
Celery Soup
Fried Codfish, Tartar Sauce
Baked Stuffed Potatoes
Buttered Cauliflower
Perfection Salad
Apple Dumplings
•
Cream of Potato Soup
Spanish Omelet, Celery, Onion and Tomato Sauce
Buttered Green Beans
Vegetable Aspic Salad
Bartlett Pears, Cookies

10
Tomato Juice
Ham, Eggs
•
Creole Soup
Beef With Noodles
Boiled Potatoes
Buttered New Turnips
Assorted Relishes
Sponge Cake With Orange Sauce
•
Vegetable Soup
Goldenrod Asparagus on Toast
Baked Squash
Combination Fruit Salad

11
Applesauce
Jelly Roll, Toast
•
Clear Broth
Smothered Chicken, Gravy
Mashed Potatoes
Creamed Peas
Lettuce, Fr. Dressing
Banana Ice Cream, Cup Cakes
•
Cream of Tomato Soup
Hamburger
Buttered Corn
Julienne Vegetable Salad
Green Gage Plums
Chocolate Cake

12
Half Grapefruit
Coddled Eggs, Toast
•
Creole Soup
Baked Heart, Dressing
Escalloped Potatoes
Spinach With Slice of Egg
Peach and Red Cherr
Salad, Whipped Cream
Tapioca Cream
•
Split Pea Soup
Escalloped Salmon
Buttered Tomatoes
Stuffed Celery With Cottage Cheese
Pineapple Ring

13
Stewed Apricots
Egg Omelet, Coffee Cake
•
Tomato Soup
Roast Beef, Horseradish Sauce, Brown Gravy
Buttered Cubed Beets
Head Lettuce Salad With Mayonnaise
Washington Pie
•
Cream of Chicken Soup
Mashed Sweet Potatoes With Marshmallows
Link Sausages
Green Peas
Fruit Gelatin Salad
Baked Apples With Raisins

14
Fruit Compote
Toast, Bacon
•
Celery and Potato Soup
Lamb Chops, Gravy
Parslied Potatoes
Buttered Green Beans
Sliced Tomato Salad With Mayonnaise
Chocolate Ice Cream, Wafers
•
Cream of Corn Soup
Mixed Cooked Vegetables
Citrus Fruit Sections With French Dressing
Blackberries, Royal Anne Cherries

15
Applesauce
Scrambled Eggs, Muffins
•
Tomato Juice
Fricassee Chicken
Candied Sweet Potatoes
Buttered Cauliflower
Tropical Fruit With Mayonnaise
Mocha Charlotte Russe
•
Vegetable Soup
Rice Baked With Meat Balls, Tomato Sauce
Buttered Whole Carrots
Cranberry Salad
Sliced Peaches
Oatmeal Cookies

16
Graepfruit Sections
Coddled Eggs, Sweet Rolls
•
Tomato Soup
Escalloped Tuna Fish With Noodles
Harvard Beets
Assorted Relishes
Orange Ice, Wafers
•
Cream of Potato Soup
Grilled Ham
Baked Bananas
Vegetable Plate
Pineapple and Red Cherry Salad
Apricots, Cup Cakes

17
Stewed Apricots
Baked Eggs, Toast, Jelly
•
Clam Chowder
Broiled Liver
Baked Potatoes
Creamed Celery
Stuffed Tomatoes With Fresh Vegetables
Red Cherry Cobbler
•
Cream of Lima Bean Soup
Stewed Corn
Asparagus
Baked Squash
Banana Nut Salad With Mayonnaise
Blue Plums, Wafers

18
Sliced Oranges
Coffee Cake, Bacon
•
Okra Soup
Baked Ham
Escalloped Potatoes
Baked Squash
Stuffed Prune Salad With Cottage Cheese
Chocolate Sundae
Chocolate Sauce, Cookies
•
Cream of Chicken Noodle Soup
Eggs à la Goldenrod
Head Lettuce Salad With French Dressing
Baked Sliced Apples, Spice Cookies

19
Stewed Apples
Poached Eggs, Milk Toast
•
Creole Soup
Salisbury Patties
Baked Sweet Potatoes
Long String Beans With Strips of Pimento, Boiled Dressing
Gelatin With Whipped Cream
•
Vegetable Soup
Baked Macaroni and Cheese
Stewed Tomatoes
Fruit Salad With Mayonnaise
White Grapes, Cup Cakes

20
Mixed Fruit Juice
Omelet, Muffins, Jam
•
Celery Soup
Pork Roast With Prunes
Mashed Potatoes, Gravy
Browned Parsnips
Perfection Salad
Ginger Bread With Whipped Cream
•
Mushroom Consommé
Potatoes au Gratin
Cold Meat
Cubed Beets in Lemon Gelatin
Fruit Cup, Angel Food Cake

21
Grapefruit Sections
Bacon, Toast
•
Bouillon
Baked Beef
Plain Potatoes
Stewed Tomatoes
Lettuce and Egg Salad, Boiled Dressing
Prune Whip
•
Mutton Broth With Barley
Creamed Beef on Toast
Buttered Green Beans
Crushed Pineapple With Bananas

22
Applesauce
Boiled Eggs, Toast
•
Corn Soup
Meat Loaf With Mushroom Sauce
Parsley Potatoes
Lima Beans
Head Lettuce Salad With 1000 Island Dressing
Maple Nut Mold
•
Vegetable Soup
Chicken With Rice, Egg Sauce
Baked Sweet Potatoes
Braised Celery
Stuffed Dates, Whipped Cream Dressing
Sliced Peaches, Cookies

23
Fruit Compote
Baked Eggs and Ham
•
Cream of Pea Soup
Swiss Steak, Gravy
Mashed Potatoes
Cubed New Turnips
Assorted Relishes
Pineapple Bavarian
•
Cream of Mushroom Soup
Carrot Soufflé With Sauce
Buttered Swiss Chard
Royal Anne Cherries, Blackberries, Angel Cake

24
Orange Juice
Scrambled Eggs, Toast
•
Cream of Tomato Soup
Escalloped Oysters
Baked Potatoes
Buttered Peas
Fruit Salad With Cranberry Dressing
Lemon Pudding With Red Cherry
•
Creole Soup
Breaded Pork Steak
Browned Potatoes
Baked Acorn Squash
Cauliflower and Orange Salad
Melba Peaches, Cookies*

25
Half Grapefruit Chilled
Bacon, Sweet Rolls
•
Roast Turkey
Mashed Potatoes, Giblet Gravy, Cranberries
Buttered Green Beans
Celery, Pickles, Olives
Perfection Salad
Christmas Cookies
Pistachio Ice Cream, Mints
•
Cream of Potato Soup
Vegetable Plate With Spaghetti
Buttered Peas
Stewed Apples, Fruit Cake

26
Prunes
Boiled Eggs, Toast
•
Crab Stew
Veal Steak, Brown Gravy
Parslied Potatoes
Harvard Beets
Cole Slaw With French Dressing
Bread and Butter Pudding With Custard Sauce
•
Cream of Celery Soup
Rice Croquettes
Stewed Tomatoes
Pineapple Ring With Red Cherries and Mayonnaise
Apricots, Holiday Cookies

27
Half Orange
Omelet, Toast, Jelly
•
Green Bean Soup
Ham Loaf
Candied Sweet Potatoes
Chopped Spinach in Cream
Head Lettuce Salad With French Dressing
Date Pudding With Sauce
•
Cream of Chicken Soup
Mushrooms on Toast
Stuffed Baked Potatoes With Cheese
Apple and Lime Salad
White Cake, White Grapes

28
Stewed Apples
Poached Eggs, Berry Muffins
•
Tomato and Rice Soup
Roast Beef, Brown Gravy
Mashed Potatoes, Dumplings
Browned Parsnips
Mixed Fresh Vegetable Salad
English Toffee Ice Cream, Wafers
•
Okra Soup
Chicken à la King
Steamed Rice With Peas
Cranberry Orange Salad
Peach Halves, Cookies

29
Figs
Bacon, Sweet Rolls, Jam
•
Consommé
Sautéed Liver, Apple Rings
Creamed Potatoes
Buttered Wax Beans
Pickled Beets, Egg Slices
Olive
Chocolate Pudding
•
Corn and Green Pepper Soup
Baked Egg in Stuffed Baked Potato With Cheese
Escalloped Tomatoes
Red Raspberries, Wafers

30
Stewed Raisins
Boiled Eggs
•
Tomato Essence
Pan Fried Haddock Fillets With Lemon Rings
Riced Potatoes With Pimento
Brussel Sprouts
Jellied Horseradish Salad With Celery
Cherry Upside Down Cake
•
Consommé
Welsh Rarebit on Toast
Baked Stuffed Tomato
Pink and White Grapefruit Sections With Mayonnaise
Baked Apples

31
Applesauce, Scrambled Eggs, Coffee, Cake • Creole Soup, Boiled Leg of Lamb, Celery and Caper Sauce, Creamed Potatoes, Buttered Peas, Grated Carrot and Raisin Salad With Mayonnaise, Cranberry Pie • Cream of Potato Soup, Fried Ham, Cream Gravy, Boiled Rice, Cucumber and Tomato Salad With Boiled Dressing, Royal Anne Cherries, Angel Food Cake.

Ready-to-eat or cooked cereals are offered on all breakfast menus.

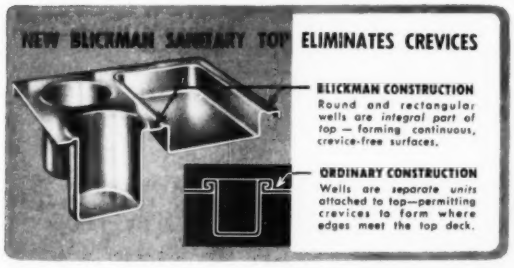
*Christmas wreath cookies

What food inset arrangement

DO YOU NEED?

One Conveyor Now Gives You a Wide Variety of Combinations for Your Selective Menus

● The top deck arrangements shown here are only a few of the many variations possible with the Blickman "Selective Menu" Food Conveyor. Eighteen square and rectangular insets are furnished in six different sizes. Variations in arrangement can be made to suit your specific needs simply by inserting the combination of insets you require. Your "selective menu" system can work smoothly and efficiently with this modern food conveyor. You can now offer your patients a great variety of meats, fish and vegetables, always kitchen-fresh and palatable. Two conventional round utensils provide for soup and broth. Two heated drawers provide for eight additional special diets. Blickman-Built food conveyors are made of enduring, sanitary stainless steel. It is the only standard truck made with a one-piece, crevice-free body and sanitary, seamless top deck construction. Consult us about your "selective menu" problems.



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explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.

Blickman-Built
Hospital Equipment

S. BLICKMAN, INC., 1511 GREGORY AVENUE, WEEHAWKEN, N. J.

PLANNING THE HOSPITAL LAUNDRY

GLENN R. STUDEBAKER
Office of Hospital Services, Division of Hospital Facilities
Public Health Service
Federal Security Agency

WHILE most patients readily accept the professional services of their doctors and nurses with the minimum amount of criticism, they can and do judge the hospital by the personal care and attention given to them while they are confined to a hospital bed. Criticism of the linen service by both patients and personnel is one of the most frequent complaints heard in the hospitals. The major share of this criticism can be avoided by properly planned linen and laundry services.

Such attention to the personal needs and comfort of the patient is as important as the physician's orders for medication or for appetizing food served promptly and with attention to eye-appeal. Necessary to this service is an adequate supply of clean linen sufficient for the comfort and safety of the patient and the personal appearance and dress of all personnel who have the responsibility for attendance to patients. Pleasant, neatly attired employes in fresh crisp uniforms do much to sell the hospital to the public.

STUDY HOSPITAL'S SERVICES

Intelligent planning for the linen and laundry services, essential to good hospital care, is not possible without a knowledge of the types of services that the hospital contemplates. They must be planned in relationship to the total bed capacity, the allotment of beds to the various services, the diagnostic and therapeutic facilities that will be installed, the extent of service facilities, including the dietary department, mechanical and other services. Also necessary is a detailed knowledge of plans for a school of nursing and quarters for personnel.

The individual responsible for planning these services will have available, or will arrive at, sound figures by visiting comparable hospitals to obtain the benefit of their operating experience as it relates not only to laundry and linen needs but also to methods of linen control. To gather this information he should personally interview the administrator, the director of nurses, the dietitian, the housekeeper, and the laundry manager of each institution visited.

The average amount of circulating patient linen has been found to be a minimum of four times the complete complement of that in use at one time. This allows one set to be in use, one set at the laundry, one available for immediate use, and one for standby and emergency purposes.

To this expected daily load of patients' linen must be added the daily load from other sources, such as the dietary department, operating room, delivery room, outpatient department, clinics, emergency room and employes' uniforms. The amount of bed and room linen for students and other employe residences must be taken into consideration. Some institutions also do personal laundry for employes. Individual items for these various services, while not required in the same ratio as that given for patients' linen, will amount to a sizable part of the laundry load.

The total laundry load is usually expressed in pounds of soiled linen per day. The average figure ordinarily used for general hospitals is from 10 to 12 pounds of soiled linen per patient each day, which usually includes both the direct (patient service) and indirect (employe and other) linen usage. For chronic disease hospitals, *i.e.* tuberculosis and mental diseases, this average will be from 6 to 9 pounds per patient per day.

For accuracy, actual measurement of the load in an existing comparable hospital should be undertaken. Dependent upon the amount of each of the several linen items in common use, a sufficient number of each should be weighed and an average weight for that piece should be determined. As an example, all sheets for one day's wash should be counted, the total quantity weighed and the average weight per piece obtained.

In a hospital with an average of 100 patients the amount of linen expected per day would be approximately 1200 pounds. This figure is computed on the basis of 12 pounds of soiled linen per patient per day. At an average of two pieces to the pound, the daily work load would then be approximately 2400 pieces.

ADVANTAGES OF A LAUNDRY

With the total daily load determined, the individuals or committee responsible for policies and disbursement of funds for construction and operation of the hospital must answer the question of whether the hospital should install and operate its own laundry or whether it would be more economical and advantageous to provide the linen and have the laundry work done outside by a commercial firm.

For hospitals with more than 50 beds, the consensus appears to be that it is usually more economical and more satisfactory for the hospital to operate its own laundry. For hospitals of less than 50 beds, opinion is divided and the problem has not been sufficiently studied to provide the answer at this time.

Should the linen be sent to a commercial laundry, approximately 20 per cent larger linen inventory must be maintained to forestall delays in delivery. Dependability of the service, including possible increased damage to linen, must be taken into consideration in reaching a decision.

The comparative costs of handling work in the hospital's laundry or sending it out must be figured on a per pound or per piece basis. In making these calculations, losses, repairs and the necessity for setting up a checking

How to add beauty and stop noise in hospitals

HOSPITALS often need acoustical ceilings that are decorative as well as efficient. Armstrong's Travertone meets these requirements fully. In addition, it is fire-safe.

Travertone is a mineral wool acoustical tile with a white fissured surface of unusual beauty. Its distinctive appearance lends itself equally well to traditional and modern interiors. It is especially suited for use in entrance foyers and private offices. Travertone absorbs up to 70% of all sound that strikes its surface.

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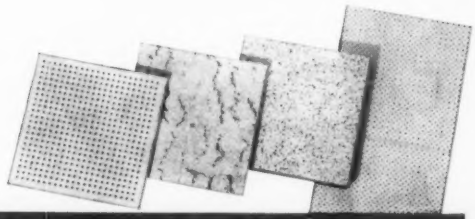

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in and out system need to be considered as well as the operating costs. Costs for a hospital laundry will probably be from 4 to 6 cents a pound. This can be materially reduced if the hospital laundry is efficiently operated and equipped with modern labor saving machinery.

The cost of operating the hospital laundry will be determined largely by:

1. The initial expenditure for equipment and space requirements.
2. Personnel requirements.
3. A satisfactory location considering economy of operation, transportation and possibilities for expansion.
4. Cost of supplies and maintenance.
5. Efficiency of operation as checked against attainable standards.

INITIAL EQUIPMENT AND SPACE

The average requirement for laundry purposes alone, excluding central linen room, sewing room, and soiled linen room, totals approximately 935 square feet for a 50 bed hospital, 1220 square feet for a 100 bed hospital, and 2020 square feet for a 200 bed hospital. Initial laundry machinery for these sizes of hospitals will average approximately $170 per bed for 50 to 100 beds, and $145 per bed for 100 to 200 bed hospitals. For estimating operating costs, steam requirements can be approximated at 7 pounds per 1 pound of linen washed. Electrical consumption totals approximately 3 kw. per 100 pounds of linen washed. These figures assume good working conditions and use of modern equipment. They will serve as a check against figures determined by an analysis of existing operating conditions or they may be calculated locally for a new installation.

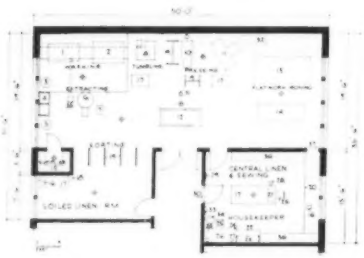
Equipment lists for various size hospitals are available. As mentioned before, a hospital with an average of 100 patients will have about 12 pounds of laundry per day per patient or a total of 8400 pounds of laundry weekly. Assuming that a 44 hour work week is in effect, this would require processing of 190 pounds per hour. A 36 by 36 inch washer can process 80 pounds per hour, while a 36 by 54 inch washer can process 120 pounds per hour, so that these two items would be minimum. One 30 inch extractor is capable of processing 255 pounds of laundry per hour; hence, it would be sufficient for a 100 bed hospital. Approximately 28 to 30 per cent of the laundry is processed through a tumbler; therefore this equipment should be capable of handling at least 80 pounds per hour. This can be done with a 36 by 30 inch machine.

In sizing the laundry plant to assure a balanced production, it must be kept in mind that flatwork will be running through the laundry seven hours a day. The flow of the flatwork is usually the governing factor in planning the layout. It is common practice for nurses to change patients' beds early in the day and flatwork immediately goes to the laundry. Common laundry practice is to put through the washer one or two loads of flatwork in order to have sufficient work ready for the flatwork ironer and to maintain production at a high level.

The rough dry work generally follows through from one to two hours after the flatwork is started. This means that the tumblers operate only on an average of six hours per day, and it is necessary to provide sufficient capacity

LAUNDRY FOR A 50-BED GENERAL HOSPITAL 1/

Suggested Equipment Layout Plan

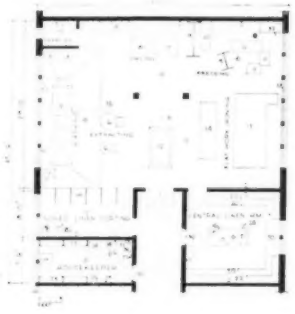


Fixed Equipment List (Group I)

Legends — Laundry for a 50-Bed General Hospital. 1. Metal washer, 24 by 36 in. 2. Metal washer, 36 by 36 in. 3. Soap tank, 30 gal. 4. Double compartment laundry trays. 5. Starch cooker, 15 gal. 6. Extractor, 26 in. 7. Platform scale. 8. Tumbler, 36 by 30 in. 9. Uniform rack. 10. Ironing board. 11. Press, 54 in. 12. Shakeout table with sloping sides. 13. Flat work ironer, 100 in. 14. Table, 36 by 96 in. 15. Shelving. 16. Marking machine. 17. Tables, 2-24 by 36 in., 1-24 by 60 in., 1-36 by 90 in. 18. Shelf over table. 19. Sorting bins. 20. Counter, 36 in. high with shelving below. 21. Sewing machine. 22. Counter, 30 in. high with cabinets below. 23. Wall cabinet. 24. Filing cabinets below counter. 25. Straight chair. 26. Counter 30 in. high, open below with drawers. 27. Telephone outlet. 28. Floor outlet. 29. Hook strip. 30. Dutch door. 31. Floor drain. 32. Compressor. 33. Bulletin board, 26 by 24 in. 34. Waste paper receptacle. 35. Sump. 36. Shelving with bins. 37. Pass window.

LAUNDRY FOR A 100-BED GENERAL HOSPITAL 1/

Suggested Equipment Layout Plan



Fixed Equipment List (Group I)

Laundry for a 100-Bed General Hospital. 1. Metal washer, 36 by 54 in. 2. Metal washer, 36 by 36 in. 3. Soap tank, 30 gal. 4. Double compartment laundry trays. 5. Starch cooker, 15 gal. 6. Extractor, 1-17 in. and 1-26 in. 7. Platform scale. 8. Tumbler, 36 by 30 in. 9. Uniform rack. 10. Ironing board. 11. Utility press. 12. Shakeout table with sloping sides. 13. Flat work ironer, 2 roll, 120 in. 14. Table, 36 by 120 in. 15. Shelving. 16. Marking machine. 17. Tables, 1-24 by 30 in., 1-24 by 64 in., 1-36 by 84 in., 1-32 by 48 in. 18. Shelf over table. 19. Sorting bins. 20. Counter, 36 in. high with shelving below. 21. Sewing machine. 22. Shelving with bins. 23. Wall cabinet. 24. Filing cabinet. 25. Straight chair. 26. Desk. 27. Telephone outlet. 28. Floor outlet. 29. Hook strip. 30. Dutch door. 31. Floor drain. 32. Compressor. 33. Bulletin board, 26 by 24 in. 34. Waste paper receptacle. 35. Sump.

1/ From "Elements of the General Hospital" reprinted from Hospitals, May 1946. Prepared by Division of Hospital Facilities, Public Health Service, Federal Security Agency.

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Yes, in terms of zero-soft water output per dollar of investment, a $1205.00 softener for $201.00, is merely typical of the savings effected by Elgin in hundreds of plants.

This has been accomplished through remodeling existing softeners by equipping them with Elgin "Double-Check" manifolds—a basic and exclusive feature of the advanced Elgin "Double-Check" Water Softener. Here is how it figured out in one case:

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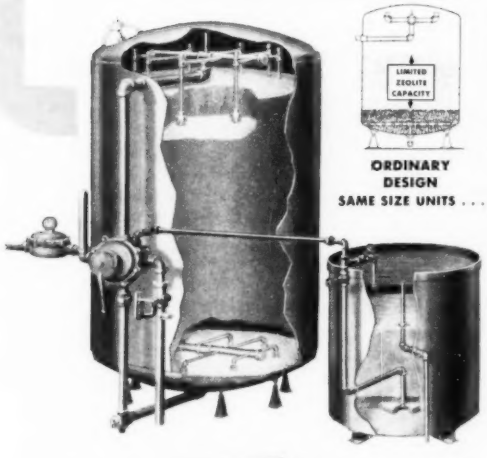
Will you pay 201 dollars for a 1205 dollar softener? Of course no single set of figures is representative of all jobs. In some cases it might be necessary to replace all zeolite, and in a few cases the softener might prove beyond remodeling, but in far more cases the results and savings are as remarkable as this. Isn't this worth looking into? Simply mail the coupon for complete information.

ELGIN SOFTENER CORPORATION, 144 North Grove Ave., Elgin, Ill.



ORDINARY DESIGN **ELGIN DESIGN**
SAME SIZE UNITS . . . SAME TYPE ZEOLITE

Your remodeled softener gives you the equivalent of this-

The Elgin "Double-Check" Softener, illustrated, gives up to 44% more soft water per regeneration than other softeners of the same size containing the same type of zeolite.

The accompanying diagrams show why this remarkable performance is possible. Note that a softener of ordinary design is limited to a far smaller bed of zeolite because it has no means of preventing the escape of zeolite during backwashing.

In the Elgin, the "Double-Check" manifold prevents loss of zeolite even at far higher backwash rates. The deeper bed means more soft water output, and the higher backwash rate along with better distribution means better cleansing of the bed, more thorough regeneration, *more efficient utilization of more zeolite.*

ELGIN
ECONOMICAL WATER CONDITIONING

Coupon brings facts

I am interested in the remodeling and modernization of my water softener.

NAME _____

COMPANY _____

ADDRESS _____

_____

Mail to Elgin Softener Corporation, Elgin, Illinois

to handle the eight hour load in the six hours that they will generally operate. Approximately 65 to 70 per cent of the laundry can be processed through a flatwork ironer, at the rate of 133 pounds per hour. A two-roll 120 inch ironer can accomplish this under ordinary loads. A single long and two small oval presses would be sufficient to process the 3 to 5 per cent of press work.

In the selection of the initial equipment the possibilities of labor saving by use of automatic controls, self-dumping and loading equipment, and flatwork folders should be thoroughly considered. The use of a mushroom press should be investigated if the analysis of the work indicates a considerable amount of expensive hand ironing will be required.

STAFFING CHART

Job Classification of Employes by Duties	Estimated Maximum Labor Requirements for General Hospitals of Bed Capacities of			Note
	50	100	200	
1. Laundry manager	..	..	1	Supervisory
2. L. M. and washman	1	1	1	Working foreman
3. Sorters and loaders	..	..	1	
4. Extractor operator	..	1	1	
5. Flatwork and rough dry crew	..	6	6	
6. Press operator	..	2	3	
7. Utility and linen room operator	..	1	1	
8. Hand ironer	..	..	1	Hand ironing required by press operators.
9. All around operators	3	..	..	
TOTALS	4	11	15	

PERSONNEL

The key to successful and efficient operation of the laundry is the selection of a technically trained, experienced laundry manager. For administrators of existing hospitals who feel that their present laundry manager is lacking in these qualifications it is recommended that he be given a course in laundry management at any well recognized trade school or institute where this subject is taught. Membership in a laundry trade association and subscription to trade journals are as important to the laundry manager as membership in the American Hospital Association is to the administrator.

In addition to the laundry manager who in smaller hospitals must also act as working foreman, there will be required sufficient personnel to handle the anticipated work load.

Numerous time, motion and operational studies have developed the fact that an average worker may be expected to process linen at the rate of 125 to 175 pounds in the course of each eight-hour day.

As a guide for the architect or person responsible for planning the laundry layout in determining how much space must be provided for rest and washrooms for laundry personnel, the accompanying staffing chart is presented. It has been developed from the experience of a leading manufacturer of laundry machinery and presupposes a 44 hour week and the use of modern high capacity equipment.

This is the first of two articles on "Planning the Laundry." The second will appear in the December issue of this magazine.

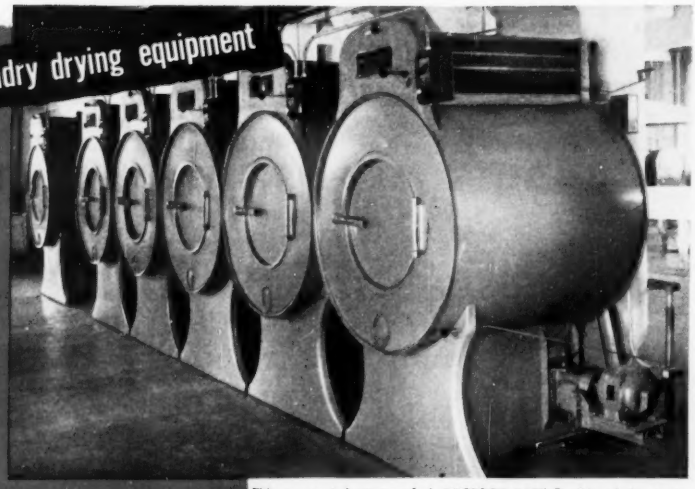
When you invest in laundry drying equipment

get more for your money

with

HUEBSCH "42"

Open-End Tumbler for large volume drying



This compact battery of 6 HUEBSCH "42" Tumblers help serve all Milwaukee County Institutions. Each of the HUEBSCH "42's" has double the capacity of a 36" x 30" 4-coil laundry tumbler.

Here are Money-Saving Advantages that make the HUEBSCH "42" such a Sound Investment

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2. FASTER DRYING. The HUEBSCH "42" will substantially outdry larger and more expensive cylinder-door type tumblers.
3. CUTS MAN-HOURS because it's easier to operate. Faster to load and unload. No cylinder doors to open. No braking or inching.
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5. LESS MAINTENANCE. Famous HUEBSCH construction means lasting durability, long trouble-free life.

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●

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Ideal for all laundry installations where steam is not available or as an additional unit for extra capacity in steam laundries. Three sizes, 36" x 30", 36" x 24", 36" x 18". Low gas consumption. Fast drying. Trouble-free operation. Has all HUEBSCH design and construction advantages. Low cost.

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Boston University Presents—

A BUDGET MEANS INTELLIGENT PLANNING

CHARLES E. BERRY
Assistant Director, Mount Auburn Hospital, Cambridge, Mass.

HAVING completed the salary estimates, you will be ready for a start on the budget for supplies. To do a good job on this portion of your budget, you must have more detailed information than is readily available to the housekeeper. Your first step should be the listing of all the supplies used in your section. This should include not only linen and uniforms, but soaps, paper goods, wax and so forth. Once you have such a list you should estimate the quantity you will need for the budget period under consideration. This task can be simplified by asking the purchasing agent or storeroom clerk what quantities have been issued during the previous period. If such records are not kept by them, your accounting office, if it operates on the accrual basis, can surely give you the costs and quantities from the invoices, but this is a long and time-consuming project and the accountant may be averse to doing it unless it is absolutely necessary. However, the average experienced housekeeper can usually rely upon her common sense to arrive at a figure that will be sufficiently accurate.

ESTIMATE PRICES

After the quantities needed have been determined they must then be priced. Here you will have to ask the purchasing agent to advise you as to costs, or if there is no such department, query the person who actually buys these commodities. Such a person should be able to suggest possible price trends and fluctuations. Much of the information is available to everyone. By spending 10 or 15 minutes reading the reports as they appear in some of the local evening papers you may have the benefit of expert thinking. Most of these articles are hidden away among stock market quotations and usually they are very short, but concise analyses in the field under discussion. For example, you may read a short paragraph which tells the growth in the number and sale of petroleum detergents. Assuming the report is true, the natural result will be a decreased demand for soaps with the possibility of lower prices; in any event no price increase will be attempted by the larger manufacturers of soaps. Many such items need no expert to interpret their general meaning.

When you have listed and priced the coming year's supplies it is always well to double check your work. This can be quickly accomplished by comparing your over-all tentative cost with the cost of supplies for the previous year, another figure that is available in most annual reports or in any event from the accountant. If there seems to be a discrepancy, pay particular attention to the miscellaneous account of the bookkeeping office. As previously explained, the accounting system probably provides for a partial breakdown for ease in determining over-all cost, and your supplies may be listed under paper goods, linen, uniforms, soaps, repair of equipment, special service, *i.e.* outside contracts for window washing, and as many other classifications as necessary. But we all know from experience that no matter how well we plan our work, some detail will be omitted. To take care of this situation the usual accounting system is devised to include a column entitled "miscellaneous or other expense." This is a catchall account and anything that does not logically belong under paper, linen, uniforms, and soaps will be included under miscellaneous.

In the concluding section of his lecture, Mr. Berry discusses the budgets for supplies and equipment and ways of staying within the budget after it has been set up

You have your salary totals, your estimated figure for supplies; next comes equipment. The first step is to list all present equipment, and the year in which it was purchased, its present condition and the length of time you expect it to last, and whether it will have to be replaced within the budget period. To this list add any new machinery or equipment that you want and need for your department. Those items that you feel will give service for another year can be disregarded but the remaining items on the list must be carefully reviewed.

LIST EACH ITEM

In preparing replacement requirements, it is desirable to list each item separately, giving the complete history of the machine, its original cost if known, date of purchase, its uses, present condition, and the cost of replacement, together with your recommendation for the type, size, make and any other detail that will aid in your getting the machine you want. The new equipment that you need must be handled in much the same way. This will be the request that will be subjected to the closest scrutiny by the director. Be certain to obtain all the pertinent data you can: life expectancy, cost, availability, and so on. In addition, you must be prepared to sell your need to the director. He will ask why you need a floor washer now when you have done without one for years. Will it cut down on labor costs, do a better job, will it be expensive to operate, will it require skilled labor, and a dozen other more or less pertinent questions. Your job is to anticipate these questions and answer them on your budget sheets as far as possible. This saves time and is

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SERVICE REPRESENTATIVES IN 88 CITIES

more likely to meet with a favorable reception than will an unexplained request for one floor washer at $700. How will this expensive equipment affect the costs of your department? Will you have $700 added to the $40,000 expense you already know will be spent for salaries and supplies? Under the accrual system the answer is no. This item would definitely be capitalized and would not be added to the cost of running the department for the next year.

Before passing on to our next division I would like to point out one or two things that might influence the final decision on this requested purchase. Although the cost of equipment that is capitalized will not be charged directly to your department, it involves the expenditure of cash. So no matter how we play with figures, plant or equipment values and reserves, the fact remains that it takes cash in hand to make these items available. And the harassed director or manager oftener than not is handicapped because he cannot figure out just where he is going to get this all-important cash.

Briefly let us summarize what information we need before setting up our budget.

FOR SALARIES

1. Policy regarding pay increases, vacations or holidays.
2. Any pending legislation or other factors governing the supply and cost of labor.
3. Changes in physical plant that might require more or less labor.
4. Any accepted change in occupancy figures.

FOR SUPPLIES

1. Amount used in previous period.
2. Costs and price trends.
3. For checking, the value of goods used in a previous period of same duration.

FOR EQUIPMENT

1. Purpose, work it will do.
2. Type, make, model.
3. Life expectancy.
4. Availability.
5. Details as to operation.
6. Cost.

The budget is complete, and has been approved. The paper work is over but your responsibilities are not. You have been committed to a course of action and you must adapt yourself to it. Living within your budget may or may not be difficult, depending upon how well you prepared it. How can we do this? First of all review your approved estimates and set up a standard for each month. In most instances all that you need do is divide your totals by 12 to get the average for any one month. This, of course, will not be entirely accurate but will be sufficiently so for your purposes. For example, if you had estimated that you would use 100 cartons of paper towels for the year, you should use approximately eight cartons a month.

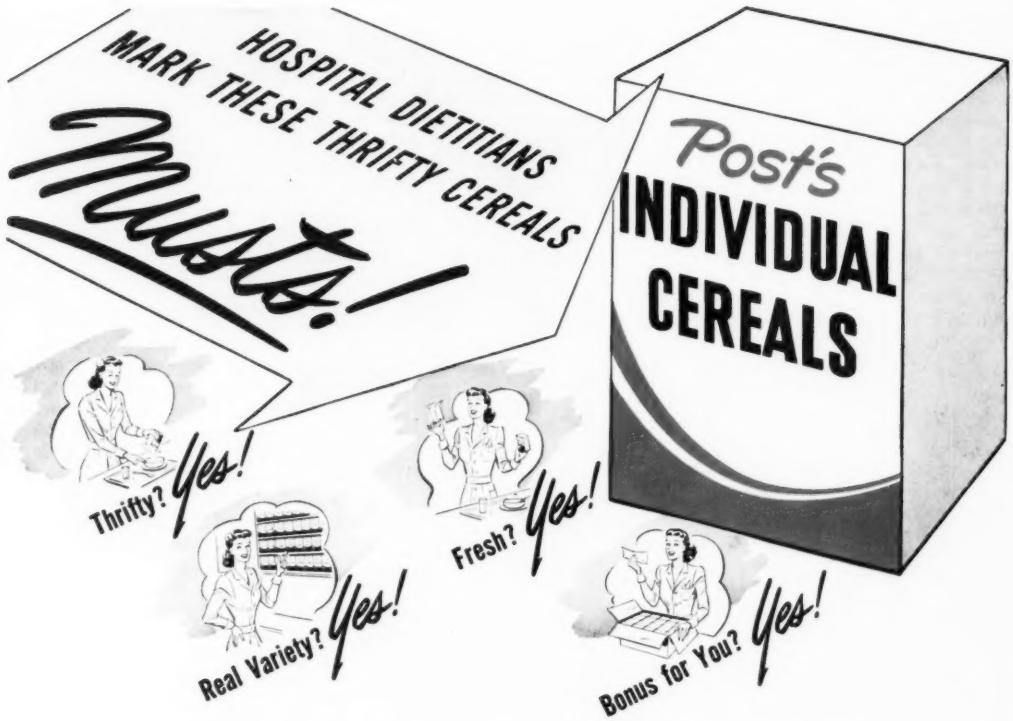
The important question that you must answer is: what can be done if 12 cartons are used? There is only one thing you can do—seek the reason. Perhaps your estimates were wrong; perhaps the occupancy figures are higher than anticipated, thus requiring more supplies; perhaps paper towels are being substituted for the usual hand towels, or perhaps there is no explanation which means that they are being wasted. If after careful investigation you find that the fault lies in your original plan, you have two courses of action: (1) you may exceed the budgeted figure for paper goods, requesting such authority from your director, or (2) you may try to live within your over-all allotment.

The efficient executive would not give the first alternative more than a passing thought, and in most hospitals it would be impossible to give it consideration. You may be told that you must adhere to the approved budget. This, however, is not as fatal as it might sound, for there are several ways it can be done, although, of course, something must be sacrificed. You may be forced to eliminate one or two positions altogether, necessitating some rearranging of the work load. If this must be done, give the matter considerable thought before taking action. The man or woman who is constantly losing time because of accidents is always a poor risk; the individual who is not adaptable does not aid morale, and those workers who cannot be depended upon to report for work are expensive to have on your pay roll. I am not going to try to advise you as to what adjustments you may make; you are far better able to determine these should it be necessary. Of course you may delay giving the wage increase as scheduled or merited or attempt to cut down on vacations and sick leave. But this approach is not only decidedly unfair and poor personnel practice but can prove very costly over a period of time. It is far better to be understaffed with people who have faith in you and your institution than to be overstaffed with unhappy employes who are staying only because they can get nothing better. When such a problem presents itself, meet it squarely, and make the adjustments in the most intelligent way possible, always starting your thinking with a consideration of your administrative labor costs.

Never let figures become your master; in other words, do not sacrifice too much just to prove your estimates were right. Remember that such things may become phobias and exclude every other consideration, to the detriment of the hotel or hospital. Savings are always welcome, but should not be made at the expense of a guest or patient or of your employes. This applies in particular to hospitals, for the patient who is seriously ill may not be able to complain if his pillows are like rocks; even if he should protest there is usually nothing further he can do about it at the time but reconcile himself to being uncomfortable. But he will not forget nor should he. In this respect hotels differ somewhat from hospitals as the guest may pack his bag and leave immediately while the unfortunate patient must remain until he is sufficiently recovered to go home or until a bed is found for him in some other hospital. Living within your budget should certainly be your goal, but it should not become an end that justifies any and all means to accomplish.

STAY WITHIN THE BUDGET

Each situation must be handled on an individual basis. No writer can tell you how to live within the budget, but he can suggest some methods of control that will aid in achieving this goal. This matter of control will be forcibly brought to your attention by your director or manager if two or three months after the budget has been approved you suddenly request additional allotments for a new desk for your office or some other item equally expensive. "Sorry, it can't be done, it is not in your budget" is likely to be his answer. He has a legitimate reason for refusing your request and you cannot attribute his refusal to any personal animosity toward the housekeeping department. You may use the same technic in a modified form by setting up similar controls. If one of your maids comes to you insisting that she must have a new set of three uniforms, when it is obvious that the ones she has are perfectly satisfactory, you can



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POST'S *Individual* CEREALS

truthfully answer that provision has been for but six uniforms a year and she must wait her turn to receive new ones. Frankly, a budget is often the perfect "out" for requests that are not legitimate or are unnecessary. Such a use of the budget may be and often is abused, and every executive must be alert to that possibility.

How will you know where you stand from time to time? The accounting office will have the data necessary at the end of each period. Such accounting periods are set up to correspond with the calendar months and the office will be able to give you the exact costs for as many items as are separated in its expense classification in the ledger. A comparison of actual costs with budgeted costs is often made in the form of a report which is circulated to all department heads. If this is not done, request the figures and set up your own comparisons. Cost figures will tell only half the story unless they are converted into quantities or items consumed or issued. Earlier, when suggesting methods for accumulating information for the first budget, I advised seeking quantities issued from your storeroom, but once you have your budget completed you should keep a simple record of what you use and when you use it.

Once you have a figure for quantities and cost, it is easy to compare it with your estimate and you may take the necessary steps to correct any discrepancies that might exist. The importance of the control factor cannot be overemphasized and your success or failure may well depend upon your ability to rectify any and all such discrepancies.

The factors of control may be effective within your own department. Since in most instances you will not be able personally to issue all supplies from a locked storeroom you may have to depend on others to use all supplies economically. By setting up a simple system of having each employe jot down just what supplies are drawn, you can soon discover what areas are extravagant in their use. Perhaps if you find that your cost for soaps is excessive you may resort to the locked closet, thereby exercising complete control over them. Regardless of what method you devise, it will serve its purpose if it enables you to know what is received, what is used, and where it is used. Then you have the essential elements of control. Having this knowledge, you will find it easy to utilize your budget in a very practical way.

A final point that should need little or no elaboration is the necessity for cooperating not only with your director but with other department heads. The value of the type of planning we have discussed is determined almost entirely by the department head. Particular emphasis should be placed upon the working relationship with the comptroller or accountant. It is this department that must handle the tremendous amount of detail involved in the operation of the hospital or hotel. You must do all you can to comply with its requests for information which may seem unimportant to you. The same spirit of willingness to help should extend toward others. If the nursing department suggests some change that will decrease the cost of its service you should carefully analyze the request before registering your opposition. Always remember that in accepting your position you pledge your loyalty to your employers, and your willingness to do everything you can to promote the efficiency of your establishment.

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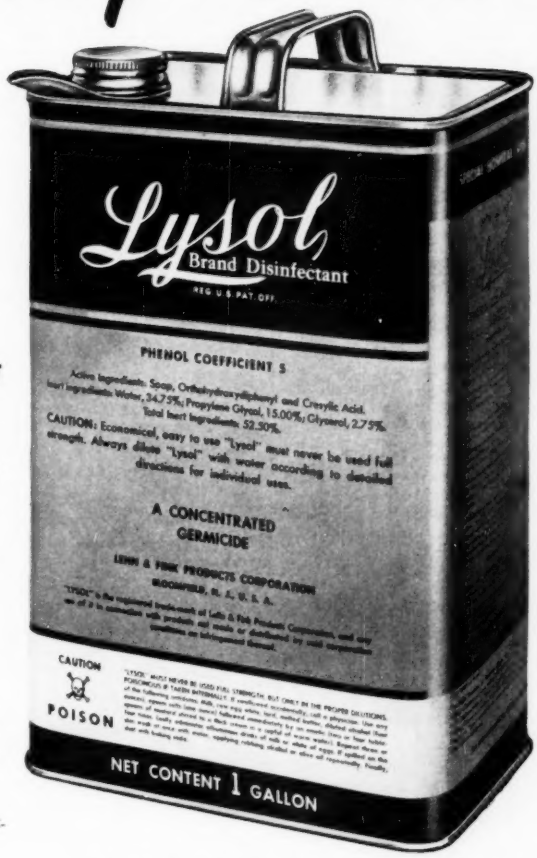

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Kinks in the Hill-Burton Act

(*Continued From Page 85.*)

ical administration and financing. This conviction does not deny that there is a place for the city or county general hospital, and it ventures no opinion as to whether in a period of inflationary costs the huge outlays required for construction and maintenance of general hospitals may not be more easily obtained through bond issues and appropriations from tax funds, but it holds that the avenue of government expenditure and control should not be entered upon until the possibilities of voluntary community action are thoroughly explored.

In the South, where the majority of all hospitals are those owned by physicians, a type of institution which is heroic and helpful in its way but inadequate and anachronistic, it would seem that the first effort toward hospital improvement should be applied, after the manner of the successful program of the Duke Endowment in North and South Carolina, to the transfer of proprietary hospitals from the limited ownership and resources of physicians to the common undertaking and responsibility of the whole community.

2. Government control forced by the unwillingness of government to meet the costs of indigent care in nonprofit hospitals must be opposed in campaigns to enlighten the public. The requirement of state administrative agencies that the new voluntary hospital must demonstrate its capacity to meet operating expenses, while ownership by the government is a sufficient guarantee of maintenance, tends to confirm the impression of present partiality toward the development of public hospitals. Experience points to a different solution, a solution which would concentrate state financing upon adequate payments to voluntary hospitals for the care of indigents.

Many devices are employed in the various states to relieve the hospitals of the financial burden involved in indigent care, but no state meets it fully. Charity is not enough—though enriching to the soul of the giver, it may debase the spirit of the recipient. Hospital service as a right should be assured to every person in need, and for the state or city to provide it through segregated charity hospitals means sometimes that the poor receive the doubtful blessings of what Dr. Fishbein calls "peasant medicine."

There should be practical ways, satisfactory to both the giver and receiver, to furnish the thing called "charity" service. As an example, consider state programs for tuberculosis care. For a minimum charge the patient is given full service. The charge by no means covers the cost, but it does lift from the patient the possible embarrassment of charity, gives him the privilege of paying what is required of him, and allows him to hold up his head as a self-respecting individual. The principle is adaptable to community hospitals and to less serious illnesses of equally impoverished patients.

Once the paying patients of nonprofit hospitals could be freed from the additional charge which hospitals must collect from them in order to care for their nonpaying guests, the possibilities of hospital self-support would be enormously increased. Par-

Canned Foods as a Source of Niacin
(NICOTINIC ACID)

No. 5 in a series which summarizes the conclusion about canned foods reached by authorities in nutrition research

Niacin is that member of the vitamin B complex which was formerly known as the "pellagra-preventive" or "P-P" factor. It is a normal constituent of all cells and functions as a component of enzymes in both glycolysis and respiration. (1)

Deficiency of niacin manifests itself in skin lesions, inflammation of mucous membranes, and when extreme, leads to symptoms of florid pellagra. Typical pellagra, however, may be the result of a multiple nutritional deficiency and is treated by the administration of not only niacin, but other members of the vitamin B complex, particularly riboflavin and thiamin. (2)

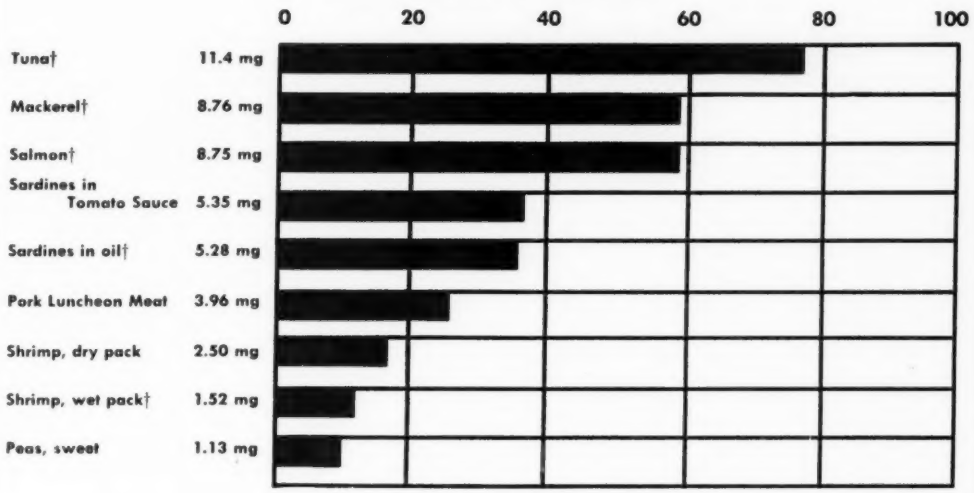
A diet rich in proteins containing tryptophane, which is believed to be a precursor of niacin, is usually recommended. (3)

Meat, fish, cereal and legumes are the best sources of niacin. These foods contain the nutrient in relatively large amounts and the daily allowance can be obtained from a serving of several of them.

Niacin is heat stable so there is a good retention of the nutrient during the canning process. A number of commercially canned foods, in particular canned fish, meat, and legumes are important sources of niacin. (4)

Percentage of Recommended Daily Allowance* in 4-oz. (113 grams) Serving (4)

(Based on analysis of the entire can contents)



†*Brine or oil discarded.*

**Percentage based on recommended daily allowance for physically active male—15 mg.—National Research Council.*

(1) 1943. *Handbook of Nutrition.* A. M. A. Council on Foods and Nutrition. Page 220. American Medical Association, Chicago.

(2) 1945. *Chemistry and Physiology of the Vitamins.* H. R. Rosenberg. Page 246. Interscience, New York.

(3) *Proc. Soc. Exp. Biol. Med.* **70**, 569-571 (1949).

(4) 1947. *The Canned Food Reference Manual.* American Can Company. Adapted from pages 251-252. New York.

ticularly is this true if the community is enlightened enough to bear not only the costs of care for indigents, but the additional stand-by, ready-to-serve costs which should be spread over the whole community because it is to the advantage of every citizen, however healthy, to have a hospital ready and able to meet his need at any time.

3. As it is everywhere held that the health center for administration of public health activities should logically be a part of the hospital, an answer must be sought to the question of how this combination may be effected when a nongovernmental hospital is involved. Considerations of the welfare of the people when both the public health center and the community hospital exist to serve call for a statement of the means by which this form of integration can be accomplished. The voluntary hospital should not be barred from such cooperation merely because the details or arrangements that are made between a public and a voluntary agency are more exacting than are those between two branches of public service.

4. Establishment of sufficient beds for tuberculous and mental and chronic patients in conjunction with general hospitals will be impossible for voluntary hospitals until the states are willing to pay higher costs for improved, decentralized programs. The wise recommendation of the Hill-Burton Act that special hospital services should be developed in conjunction with general hospitals brings to the forefront a difficult problem for the nonprofit hospital. Tuberculosis and mental diseases are classified as primarily the responsibility of the state, since they are so costly and so demoralizing to families that only the state can make adequate provision. Enlightened state and local government policies for reimbursing community hospitals for the expense of such patients as they can suitably treat would go farther toward meeting the full obligation of the state toward its citizens than would the application of similar funds to a few centralized state institutions.

5. Integration of hospital services should not have to wait too long for government aid. Many of the first construction grants had been allotted before definite and mutually beneficial relationships were established between the new hospitals and those already existing. The tendency to rush into construction of unrelated hospital units, however pressing the need, before their part in the health picture of the whole region is fully demonstrated, seems unfortunate.

Even without the influence of requirements in the federal regulations, the state plans should move forward from the drawing of lines on a map to the institution of policies and procedures under which the hospitals constructed with federal aid will be encouraged and enabled to fill a well designed and thoroughly understood place in an integrated hospital system. Since this desirable result waits upon means of reimbursement by the smaller unit to the larger hospital center for the services it would receive, a method of underwriting this increased operating cost in the interest of higher standards and better care could well be made a cardinal goal of state policy for payments to hospitals.

6. The obligation to inform the public requires concerted, continuous attention. It is the intent of the Hill-Burton Act that the responsible public agency of the state should be not obligated to build hospitals but to lead the public in meeting its recognized needs, retaining under the control of

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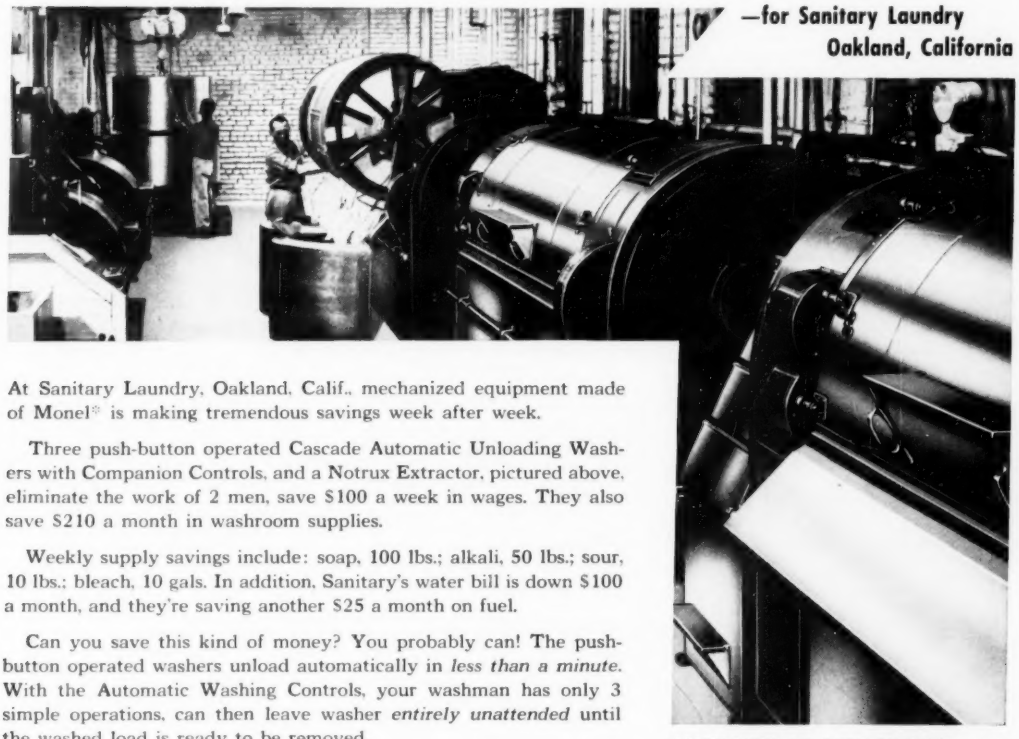

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CONTROLLED BY PUSH-BUTTONS. Easily handled by smaller washroom staff, this mechanized equipment of Monel saves 30 min. washing time on finished work, occupies 25% less floor space than machines previously used. For other savings, see text. *Photo courtesy American Laundry Machinery Co.*

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the state agency only the allotments of funds and disbursements in accordance with federal requirements. Every interested group in the state should be utilized in formulating and revising the state plan, as well as the official bodies of state and local governments. The state agency, while retaining supervisory powers in respect to fiscal and construction matters, should be primarily an agency of public education.

The state plan should be made by and with the people, not merely for the people. Carrying to the public the possibilities open to them for improved hospital service, as soon as the people are willing to unite for joint action, should command talents of a high order utilizing all mediums of popular information. Besides the lay personnel already officially attached to the state agencies as advisory committees, there should be many informed trustees and hospital workers who could tell the story. Not least among the bodies whose hearty cooperation should be counted upon in this program is the state hospital association.

7. Hospital plans confined to state boundaries must not be permitted to blight wise planning for areas extending across state lines. Though specifically provided for in the Hill-Burton Act, no report of an interstate plan has appeared in print to my knowledge, although the Public Health Service long ago made a considerable study of Memphis as the preferred hospital center of an area extending into three states.

Unless an arrangement is evolved between the hospital construction plans of adjoining states to disregard the boundary and recognize the essential unity of hospital interests of all the people in the area, unfortunate results in expensive duplication of unrelated facilities are inevitable.

Believing that the Hill-Burton Act provides most of what American hospitals need for the best interests of the American people, I can summarize my own hope for major changes in its renewal as these three: first, within the states, not only higher priorities but larger grants for communities having the greatest needs and the least resources, according to some such formula as that by which the poorest states receive proportionately larger federal grants; two, allotments of funds to promote integration actively, so that to the high principles and pious hopes of the statute may be applied the very substantial funds which alone will make it possible for base and intermediate hospitals, however willing and capably staffed, to share their professional and technical skills with neighboring intermediate and rural hospitals; and third, establishment of the principles by which interstate hospital areas may be developed by mutual consent as the law now states, again with commendable piety but with pitifully scant results.

We stand at the beginning of a new era of partnership between government and local associations of citizens which will eventually develop a national program of comprehensive and abundant hospitalization. "Progress means trouble," and there is no room for doubt that the new problems will tax our successors in different and more demanding ways. But hospitals are barely beginning to enter upon their heritage, and their progress will be determined by the measure of their ability to work together single-mindedly to provide the best possible service to patients and all the services that prevent persons from becoming patients.

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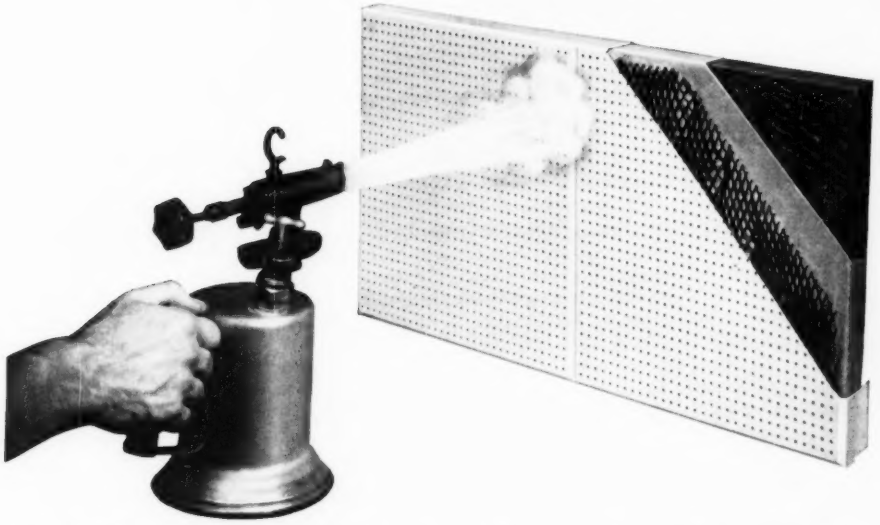

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NEWS DIGEST

A.H.A. Seeks Funds for Study of Hospital Financing . . . Nursing group Completes Survey of Schools . . . A.C.S. Delegates See Surgery Televised in Color . . . H.I.A. Reelects Murdough . . . Hospital Construction Act Extended

Seek Funds to Establish Program of Commission on Financing Hospital Care

CHICAGO. — A tentative budget of $500,000 has been established for the two-year program of the proposed commission on financing hospital care, according to a prospectus released by the American Hospital Association here last month. The committee which has developed the program is headed by Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics.

Membership in the commission will include, in addition to physicians and hospital administrators, representatives of labor, industry, the press, education, agriculture and religion, the committee's presentation stated. Nursing, prepayment plans, public health agencies and the social sciences are also to be represented on the commission, it was indicated, and one Negro member will also be selected.

The organization chart for the study calls for staff members in addition to the director and an assistant director to head up medical, hospital, statistical, accounting and economic divisions, it was explained.

"The association is persuaded not only of the importance of this study but also of the need for its inauguration at the earliest possible date," it was stated. "Authoritative guidance is required in order that an adequate quality of hospital care may be provided for all the people within the limits of resources which can be devoted to that purpose."

As explained by Dr. Bachmeyer, the study is expected to cover seven main divisions, including evaluation of the current financial position of hospitals, determination of the need and demand for hospital services, analysis of the effect of medical practice on hospital costs, establishment of means for obtaining highest quality services at lowest costs, study of prepayment systems, investigation of methods for obtaining effective utilization of hospital resources, and preparation of recommendations for accomplishing desirable changes.

The committee has estimated that the commission itself will include from 20 to 30 members. Philanthropic foundations are being approached for funds to support the enterprise.

Magnuson Outlines Plan to Obviate Need for National Health Insurance

CLEVELAND.—Voluntary hospitals can provide the service chiefly lacking in America and thus obviate the need for a national health insurance system, Dr. Paul B. Magnuson, medical director of the Veterans Administration, said in an address at the American Hospital Association convention here. The heart of the medical care problem in America is lack of diagnostic and public health facilities, Dr. Magnuson declared.

Outlining a plan for the development of outpatient diagnostic clinics based in voluntary hospitals, Dr. Magnuson said his program was a "positive middle way that avoids the false optimism of the do-nothing policy and the potential disillusionment of the other extreme." Financial support for the scheme would come from the federal government, states, local governments and private contributions, he said. Staffing of hospital clinics would be cooperative, bringing together medical schools, public health agencies and the Veterans Administration, as well as hospital staff members. Diagnostic service would be provided by the family physician, the local hospital and its specialist staff at regular rates according to the patient's economic status.

Murdough Reelected Head of Hospital Industries

CLEVELAND. — Thomas G. Murdough of the American Hospital Supply Corporation was reelected president of the Hospital Industries' Association at the annual meeting held in connection with the American Hospital Association's convention here in September. Charles E. Pain of Will Ross & Company was named vice president and George J. Hooper, Puritan Compressed Gas Co., was elected secretary-treasurer.

Edgerton Hart of Chicago will continue to serve as the association's full-time executive director, it was reported, and William Sexton of John Sexton & Company, Howard Baer of A. S. Aloe Company, and Roger Wilde of Simmons Company were named directors.

At its membership meeting, the association approved a resolution opposing compulsory health insurance or "any system of medical care designed for bureaucratic control."

Hospital Survey and Construction Act Extended

WASHINGTON, D.C.—By a vote of 235 to 43 in the session of October 3, the House of Representatives approved a bill amending the Hospital Survey and Construction Act to provide for additional funds and an extended period of operation. A similar bill was passed by the Senate last month. Differences between the Senate and House versions were to be worked out in conferences here last month.

Under the amended law, the annual federal appropriation for hospital construction will be increased from $75,000,000 to $150,000,000, and the life of the program will be extended from June 30, 1951, to June 30, 1955, it was explained.

NEWS...

Nursing Committee Completes Survey of Educational Facilities Offered by Hospitals

NEW YORK. — The subcommittee on school data analysis of the National Committee for the Improvement of Nursing Services has completed its survey of educational facilities offered at the nation's hospital nursing schools, it was announced here last month. The committee represents the joint board of the six national nursing organizations and undertook the study as a necessary preliminary to planning for the improvement of nursing services.

Ninety-six per cent of the nation's 1195 schools of nursing participated in the survey by returning extensive questionnaires issued by the subcommittee, it was reported. The participating schools also furnished descriptive bulletins and literature.

On the basis of the information furnished, a classification of basic programs in nursing has been completed and will be published in the *American Journal of Nursing* this fall, the committee said. The classification consists of two groups: Group I, including the 25 per cent of nursing schools with the highest standings, and Group II, including the 50 per cent of schools with "middle standings." The other 25 per cent of schools are not included in the classification, it was explained; this group covers schools with the lowest standings, those not returning data for survey purposes, and those which requested omission from the classification.

"The classification will be useful to groups interested in recruitment of students for future nursing service," said a statement issued by the subcommittee. "In addition to the initial use of school data for classification purposes, the study provides a wealth of material on resources of nursing education facilities which will be invaluable in regional planning for nursing education. It will be useful also to planning groups in states and communities."

According to confidential summary reports which have been issued to participating schools explaining their standing in the classifications, the factors considered in arriving at the standing of each school were student health, clinical facilities, qualifications and size of teaching staff, and instructional salaries.

Louise Knapp, dean of the school of nursing, Washington University, was chairman of the subcommittee which made the survey. Ruth Sleeper, director of the school of nursing at Massachusetts General Hospital, Boston, was alternate chairman. Mrs. Christy Hawkins was nursing consultant on the survey staff and Mrs. Margaret D. West was statistical analyst, the announcement said. Assisting the committee in analyzing data were consultants representing the American Hospital Association, American Medical Association and education, nursing and public health groups.

Surgery Televised in Color at 28th A.C.S. Standardization Conference

CHICAGO. — Surgery televised in color from the operating room of St. Luke's Hospital here featured the 28th annual hospital standardization conference of the American College of Surgeons the week of October 17. The surgical television broadcasts were viewed by hospital representatives and physicians attending the clinical congress of the college at the Stevens Hotel.

Leo Lyons, director, and Dr. Robert F. Brown, assistant administrator of St. Luke's, conducted television demonstrations of hospital procedures in addition to the surgical broadcasts for the television audience. The administrative procedures that were televised included a demonstration by the operating room supervisor and her staff showing a typical instrument setup for an appendectomy and several procedures involving the personnel and dietary departments.

In one of these demonstrations a dietary employe was shown being instructed by her supervisor in the preparation of a patient's tray; in another the employe was serving the tray in a patient's room. A third demonstration showed the preemployment interview of a prospective employe by the hospital's personnel director.

The color television equipment used in the demonstration was designed especially for surgical teaching by the research laboratories of the Columbia Broadcasting System; the equipment was designed for Smith, Kline & French Laboratories of Philadelphia and was lent to the college for the demonstration as a contribution to medical teaching. The demonstration was the third such use of color television for medical purposes, it was stated.

A number of Chicago hospitals provided demonstration tours for visiting hospital administrators during the conference, which also featured lectures and panel discussions on current problems in hospital administration.

The best radiologists are moving away from hospital practice to establish offices of their own, yet hospital practice is where the best radiologists are needed, Dr. W. Edward Chamberlain of Philadelphia told a group of hospital administrators at the conference. The reason for this anomaly, Dr. Chamberlain said, is that the hospital radiologist too often cannot control his own destiny. He is not consulted in the management of his own department; thus he is given responsibility without the accompanying authority that is needed to discharge it. The compensation of the radiologist is less important than these professional principles, Dr. Chamberlain said. He added that the fee-for-service basis was the most satisfactory method of compensation from the radiologist's point of view.

The growing importance of pathology, anesthesiology and physical medicine was traced by other conference speakers, who also stressed high professional standards rather than method or amount of the physician's payment. Speaking for the pathologists, Dr. Frank W. Hartman, laboratory director at Henry Ford Hospital, Detroit, emphasized the need for up-to-date laboratory equipment. "The most expensive thing in the hospital is labor," he declared, naming a number of procedures which can be done with modern instruments at a tremendous saving of a technician's time and expense. A great need today, he added, is for a machine which will count red blood cells.

Dr. Charles O. Molander of Michael Reese Hospital, Chicago, outlined the requirements of a physical therapy department for the modern hospital.

NEWS...

2000 Delegates to A.D.A. Meeting Hear Authorities on Medicine, Nutrition

Elizabeth Perry

DENVER.—Ten rules for dietitians to follow in instructing hospital patients were suggested by Dr. Robert S. Liggett, professor of medicine at the University of Colorado, at the 32nd annual meeting of the American Dietetic Association here last month. According to Dr. Liggett, dietitians should:

1. Establish rapport with the patient, impressing on him that the dietitian is an integral part of the team concerned with the patient's treatment.

2. Direct instruction to the patient's level of intelligence, considering both his ability to comprehend and physical state.

3. Make specific instruction, quantitatively and qualitatively, with regard for such factors as the time of day for meals, and so on.

4. Give instruction promptly and completely, without waiting until the patient's time of discharge.

5. Orient the patient in the purpose of diet, including the general principles behind restrictions. (This is actually the physician's responsibility, but should be done by the dietitian if the physician omits it in the pressure of time.)

6. Give the patient printed instructions and lists of food, specifically made up for the individual.

7. Avoid talking about the patient's symptoms.

8. Avoid frightening patients.

9. Have patients return frequently and show dietary diaries to be sure they are following diet instructions.

10. "If patients are dishonest, there is nothing you can do about it—or for them," Dr. Liggett concluded.

More than 2000 members of the association attended the four-day meeting here and heard authorities in the fields of medicine, public health, dentistry, child care, dietetics, nutrition research and food administration. The association announced that its current program of vocational guidance will be enlarged to direct the attention of students and educators toward the current need for trained dietitians in schools, hospitals, hotels and restaurants, commercial and industrial cafeterias and in dietetic research work.

Fairfax T. Proudfit, director of the dietary department of the John Gaston Hospital in Memphis, Tenn., was awarded the fifth annual Marjorie Hulsizer Copher Memorial at the annual banquet. Miss Proudfit, an instructor in the school of nursing and the college of medicine at the University of Tennessee, was cited for "pioneer work in diet therapy; her contribution to the appreciation and understanding of dietetics gained by hundreds of nurses and physicians whom she has taught; her skill in interpreting nutrition and its application to dietetics."

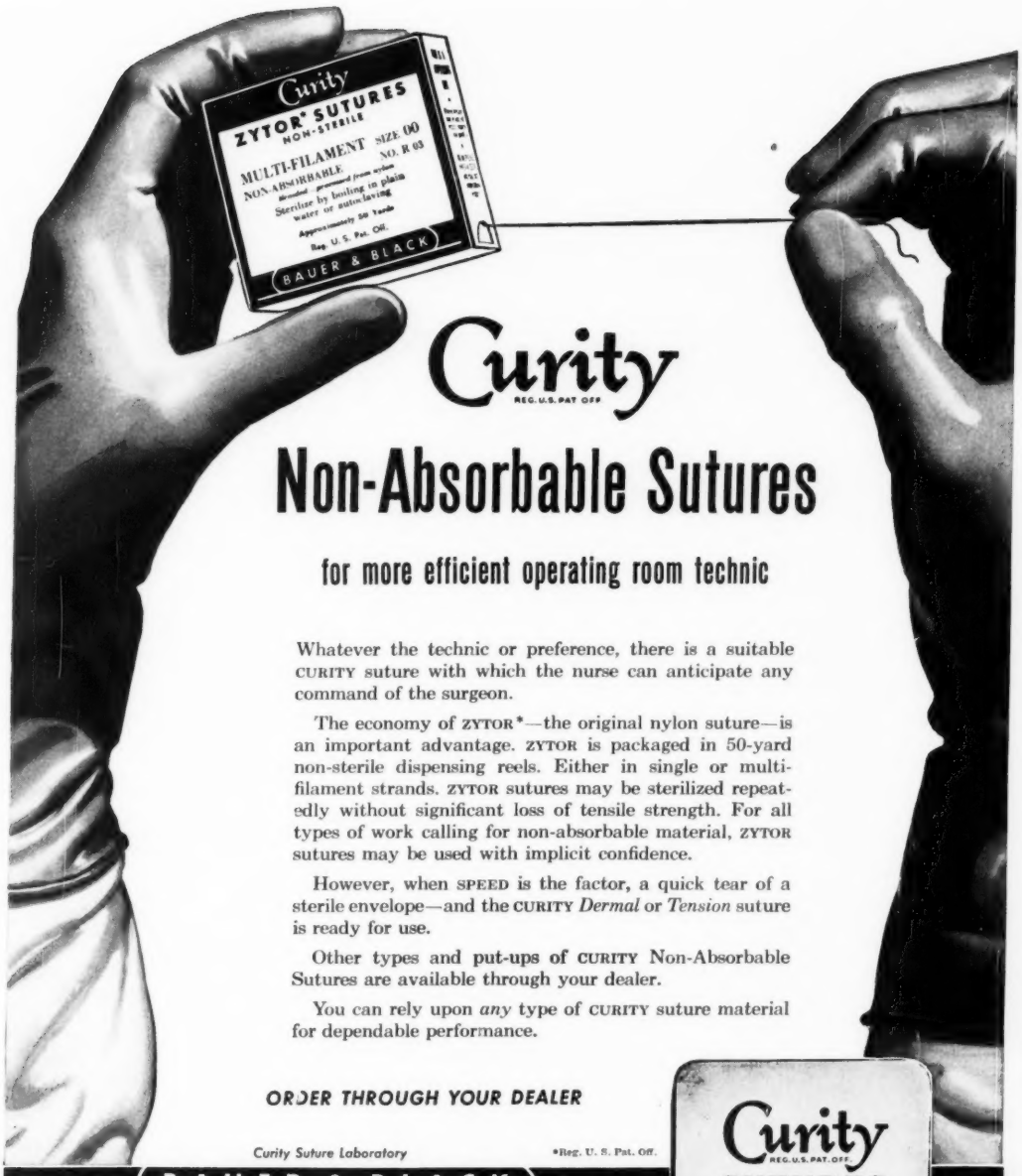
Elizabeth Perry, assistant superintendent and chief dietitian of City Hospital, Cleveland, took office as president of the association. She replaces Helen E. Walsh, nutrition consultant for the California State Department of Public Health, who was president during the 1948-49 term.

Report Indicates Use of Plastic Dishes in Hospitals

CLEVELAND.—According to a five-state survey made by Franklin D. Carr, administrator of the Waukesha Memorial Hospital, Waukesha, Wis., and reported at the American Hospital Association convention here, 25 per cent of hospitals are using plastic tableware in one or more departments. Experience reported by hospitals using the plastic dishes, Mr. Carr said, shows breakage loss appreciably lower than with chinaware. The total long-term replacement costs are expected to be approximately 50 per cent lower than with chinaware, the hospitals covered in the survey had indicated.

In another report presented at the conference of hospital purchasing agents, Donald L. Reams, general manager of the Hospital Purchasing Service of Pennsylvania, and C. Rufus Rorem, executive secretary of the Philadelphia Hospital Council, reported on experience with the central purchasing service established by the Philadelphia council two years ago.

The purchasing service now has 44 member hospitals ranging in size from 30 to 700 beds, they said. Total volume of the service has been approximately $30,000 a month for the past several months, they reported, and is expected to reach a rate of $500,000 a year in 1950.



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NEWS...

300 Federal Hospital Officials Attend Luncheon

CLEVELAND.—More than 300 officials of federal hospitals attended a special luncheon held in connection with the annual convention of the American Hospital Association here last month. Representatives of army, navy, Veterans Administration, Public Health Service and Indian Affairs hospitals heard Dr. Raymond B. Allen, president of the University of Washington and medical director of the Office of the Secretary of Defense, remind his audience that three-fourths of all the nation's hospital beds were in federal, state or local government institutions of one kind or another.

As Dr. Allen put it, "The conclusion which is so obvious that it escapes the attention of some citizens [and, he might have added, most doctors and hospital people] is that our federal government is in the business of medical care in a very large way." Plainly adding a warning to, or about, the Veterans Administration, Dr. Allen concluded: "There are certain areas of this medical care program which infringe directly on the responsibilities, prerogatives and obligations of the voluntary system. If the present trend toward all-inclusive medical care for federal beneficiaries continues, the bill to the taxpayers will inevitably increase and there will be less money to develop voluntary medical care programs."

That Dr. Allen was objecting to the size of the federal hospital bill and not the nature of federal hospital service was apparent in his introductory observation that he had never seen a more devoted, hard working group of men and women than he found in the federal medical services. "Government employes, like all the rest of us, are American citizens," he said, making a point that is frequently overlooked.

Other government programs were under discussion at other convention meetings. In one of the most illuminating presentations of the week, Dr. L. E. Burney, Indiana state health commissioner, told how the development of the state licensing program for Indiana had resulted in improved standards of organization and performance at a number of hospitals. Dr. John J. Bourke of the New York state commission described the integration of state planning and regional hospital council programs.

Drs. Vane Hoge and John McGibony dug deep into the workings of Public Law 725 and its hoped-for amendment for an audience of administrators and state survey directors.

Damage Suits Filed Against Lake Wales Hospital

LAKE WALES, FLA.—Damage suits totaling $225,000 have been filed against the Lake Wales Hospital here following the deaths of four infants attributed to absorption of aniline dye on hospital diapers, N. H. Bunting, secretary of the hospital association, revealed last month. The commercial laundry serving the hospital was also named in the damage suits, Mr. Bunting stated.

Several meetings between attorneys representing the hospital and its insurance company and doctors involved in the case have been held, it was reported. "It is difficult to foretell the outcome of the suits but we are all hoping that the insurance will be sufficient to cover the settlement, if any," Mr. Bunting said in a letter to the hospital's board of directors.

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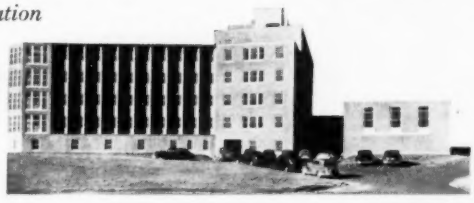

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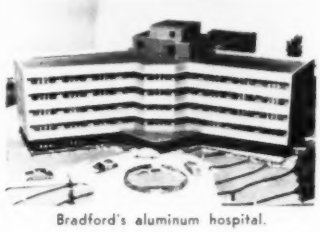
NEWS...

Bradford to Have First Hospital Built with All Aluminum Exterior

BRADFORD, PA. — The first hospital in the world to be built with an all aluminum exterior will be constructed here when the $1,800,000 new building planned for Bradford Hospital now under construction is completed in 1951, according to a story released at the hospital last month. Exterior walls of the new structure are aluminum sheets or panels $1/4$ inch thick, varying in size from $4\frac{1}{2}$ feet by 6 feet down to smaller panels. The panels are bolted to the frame structure.

"No outside scaffolding, rigging or derricks are needed for erecting the walls since the panels are taken to each floor



Bradford's aluminum hospital.

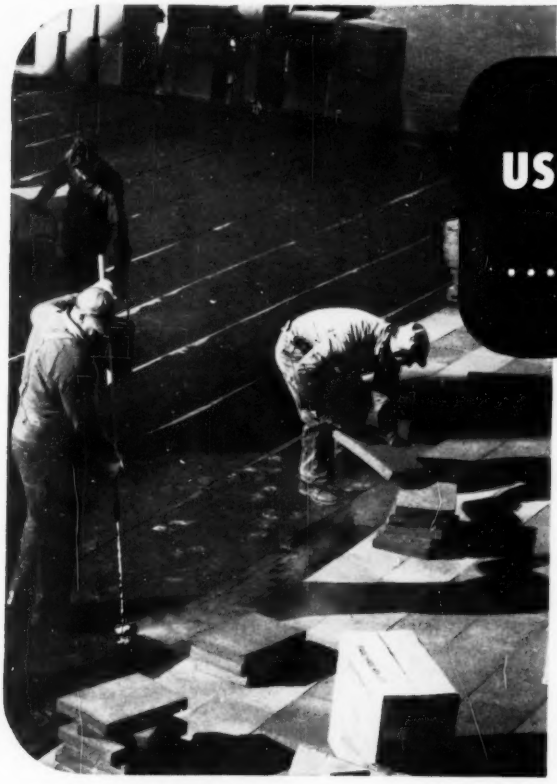
and installed from within," said the hospital release. "The building exterior will require no painting or further maintenance. The over-all cost of the new construction is competitive with conventional building design."

Thomas K. Hendryx of Bradford is the architect for the new building; John N. Hatfield, administrator of the Pennsylvania Hospital of Philadelphia, is consultant.

Four Minneapolis Hospitals Undertake Coordinated Program for Nursing Schools

MINNEAPOLIS. — A coordinated program for hospital nursing schools here has been undertaken by four major hospitals now operating separate schools, it was announced last month. The four hospitals joining forces in the new program are the Abbott, St. Barnabas, Eitel and Northwestern institutions of this city. Junior and senior students are interchanging hospitals in their clinical studies, according to availability of the best clinical facilities and instructors, Henrietta Davis, coordinator of the central nurse teaching committee and for-

avoid costly replacements



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NEWS...

mer director of nursing at Abbott Hospital, explained.

Freshmen students take a uniform six-month course in basic science at their "home" hospitals, then begin attending the clinical classes at other institutions. The central nurse teaching program was developed by a planning committee of the Minneapolis Hospital Council.

"We are attempting to improve the quality of nursing instruction," Miss Davis said, "by pooling the efforts of several schools, picking the best instructors in a particular field and the best facilities available for teaching certain subjects. What this means is that a girl at Abbott School of Nursing may attend orthopedic classes at Eitel, public health classes at St. Barnabas or obstetrics at Northwestern."

Miss Davis expressed the hope that the four-school program would prove to be only the first step toward a full-fledged centralized school of nursing for Minneapolis. Ten hospitals in the area are contributing to the program, it was explained, although only four schools are taking part in the coordinated program thus far.

Russell Nye, administrator of Northwestern Hospital, is chairman of the hospital council committee working on the centralization program and Dorothea Glasoe, director of nurses at Northwestern, is chairman of the nursing advisory committee which planned the coordinated courses.

A.C.H.A. Appoints Hayhow

CHICAGO.—Dr. Edgar Hayhow has been appointed chairman of the educational fund committee of the American College of Hospital Administrators, it was announced at college headquarters here last month. Dr. Hayhow succeeds Dr. Wilmar M. Allen of Hartford, Conn., who has relinquished chairmanship of the committee to assume the responsibilities of the college presidency, it was stated.

Heads Medical Service Office

WASHINGTON, D.C.—Dr. Richard L. Meiling of Columbus, Ohio, has been named director of the Office of Medical Services by the Secretary of Defense, it was announced here last month. Dr. Meiling succeeds Dr. Raymond B. Allen of Seattle, president of the University of Washington, who has served as acting medical director for the past several months.

NEWS...

College of Pathologists Discusses Relations of Hospitals and Specialists

CHICAGO.—Discussion of the hospital-specialist relationship featured a round-table program on contractual relations at the annual meeting of the College of American Pathologists here last month.

Dr. John R. Schenken of Nebraska Methodist Hospital at Omaha was moderator for the panel which included representatives of hospitals and the principal specialties involved in hospital practice. The discussion, while controversial, was characterized by a calm approach and objective evaluation of the situation, in the opinion of observers.

HOSPITALS CRITICIZED

Hospitals were criticized for making administrative decisions in connection with the employment and discharge of specialists without reference to the medical staff in an opening statement by Dr. William O. Russell of Houston, Tex. Hospital representatives on the panel agreed with Dr. Russell that such action should be taken by the hospital administrator only after consultation with the appropriate staff officers or committees. It was pointed out, however, that the pathologist especially is called upon to criticize individual members of the staff in the performance of his duties and should not therefore be dependent solely on staff action for his appointment.

Representing pathology, Dr. David A. Wood of Stanford University pointed out the importance of having the patient know the pathologist and urged that bills for pathological service bear the pathologist's name. He stated that the pathologist could work at a proper professional level only on an individual fee-for-service basis.

Hospital representatives denied this, arguing that there is no connection between professional standards for the pathologist and the basis of his compensation. The average patient, in fact, would be annoyed by receiving a direct fee from a doctor whom he doesn't know and did not choose, it was maintained. Pathologists must educate the public in the importance of their function in medical care before publicizing the individual pathologist, it was added.

Hospital representatives on the panel were John Hayes, Lenox Hill Hospital, New York, and Everett W. Jones, vice president of the Modern Hospital Publishing Company.

NEWS...

Anesthetists Elect Officers

CLEVELAND. — Myra Van Arsdale of St. John's Hospital here was reelected president of the American Association of Nurse Anesthetists during the association's convention here last month. Other officers elected were: first vice president, Marie N. Bader, Colorado Springs; second vice president, Verna E. Bean, Lexington, Ky.; treasurer, Mrs. Gertrude Fife, formerly director of the school of anesthesia of the University Hospitals, Cleveland, reelected for the fifteenth consecutive term.

Trustees named were: Mary A. Costello, chief nurse anesthetist at the Cincinnati General Hospital; Betty E. Lank, Children's Hospital, Boston, and Lillian Baird, University of Michigan Hospital, Ann Arbor.

COMING MEETINGS

ASSOCIATION OF CALIFORNIA HOSPITALS, Recreation Center, Santa Barbara, Nov. 17, 18.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Nov. 28, 29.

ILLINOIS HOSPITAL ASSOCIATION, Springfield, Nov. 30-Dec. 2.

KANSAS HOSPITAL ASSOCIATION, Jayhawk and Kansas Hotels, Topeka, Nov. 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

MICHIGAN HOSPITAL ASSOCIATION, Pantlind Hotel, Grand Rapids, Nov. 6-8.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Commodore Hotel, New York City, Nov. 7-9.

NEBRASKA HOSPITAL ASSEMBLY, Paxton Hotel, Omaha, Nov. 17, 18.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Hotel Tulsa, Tulsa, Nov. 17, 18.

1960

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 10, 11.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 24-27.

BOARD OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, March 1, 2.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 21.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Memorial Auditorium and Convention Hall, Buffalo, N.Y., May 24-26.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, April 12-14.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 27-29.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, March 22-24.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 6-8.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, March 7-9.

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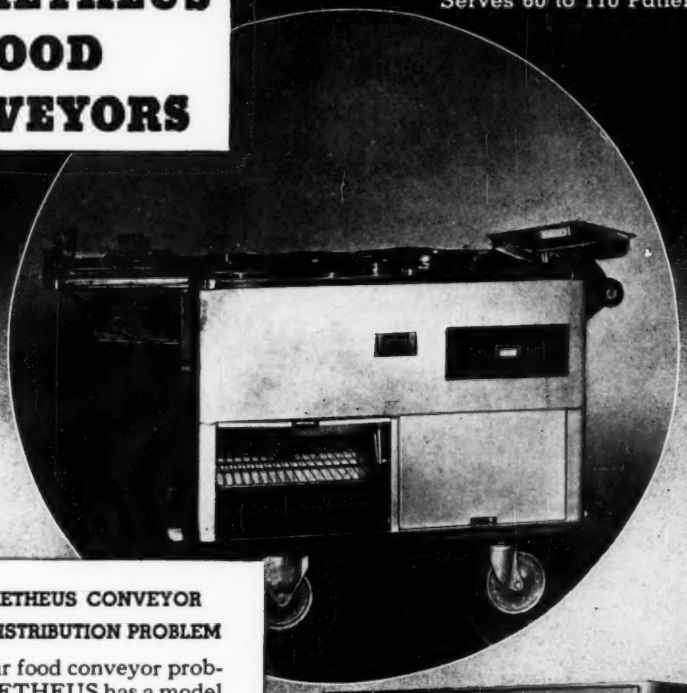

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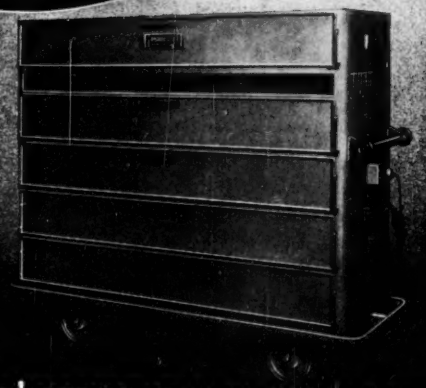

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NEWS...

$161,572,811 Paid Hospitals by 90 Blue Cross Plans in Six-Month Period

CHICAGO.—An aggregate sum of $161,572,811 was paid to hospitals by 90 nonprofit Blue Cross Plans for care of Blue Cross members during the first six months of 1949—the largest percentage of their income that these hospital care plans have paid for members' care during any previous six-month period, the Blue Cross Commission reported last month. Total income of plans for this period amounted to $184,350,857, of which 87.64 per cent was paid to hospitals, the report said.

With expenditures of only 9.11 per cent of total income, or $16,796,610 for operating expense during the same period (January 1 through June 30, 1949), Blue Cross plans established an all-time record for low cost administration, it was reported.

NEW YORK.—Hospitals in the Greater New York area were paid $20,671,437 for the care of hospitalized members of Associated Hospital Service during the first six months of 1949, it was announced last month by Louis H. Pink, president. The total represented 89.88 per cent of the organization's earned income, he said. Operating expenses, including taxes, totaled $2,226,085, or 9.68 per cent of the earned income.

PORTLAND, ORE.—Total income for Oregon Blue Cross for the first six months in 1949 was $721,212, of which 89.26 per cent went for member care, according to Frank F. Dickson, executive director, Northwest Hospital Service.

PITTSBURGH.—Blue Cross operating costs during the first half of 1949 were the lowest in the history of the plan in Western Pennsylvania, it was announced today by Abraham Oseroff, vice president of Hospital Service Association of Pittsburgh. Operating costs dropped from 8.5 per cent last year to 7.3 per cent during the first half of this year, Mr. Oseroff said. Payments to hospitals in the same period reached a total of $5,578,554, or 91.6 per cent of increase for the period.

A.M.A. Charges Politics Inspires Anti-Trust Action of Justice Department

CHICAGO.—Investigations of the American Medical Association and several county medical societies by the anti-trust division of the Department of Justice are politically inspired, it was charged here last month by Whitaker and Baxter, directors of the association's national education campaign. The Whitaker and Baxter statement described the F.B.I. investigations as "a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to compulsory health insurance."

In an official statement, the board of trustees of the association protested the investigations. "We are convinced that these are not bona fide anti-trust investigations," the trustees' statement said. "We would be naive, indeed, if we ignored the political implications of this sudden rash of investigations, attacking medical societies at a time when the administration is doing its utmost to stifle opposition to its proposed system of government controlled medical care."

The A.M.A. statement added that the American people would not tolerate "police state methods."

Tracing the sequence of events since the A.M.A. campaign was inaugurated

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NEWS...

last December, the trustees' statement also indicated that the board room at A.M.A. headquarters had been broken into and board records searched by "persons unknown."

"The facts indicate that this was a search for information rather than an ordinary burglary," the official statement said.

Fire Protective Group Adopts A.H.A. Safety Rules

The National Fire Protective Association has announced the adoption of new rules and regulations relating to safety standards in operating rooms as recommended by the Committee of Safety of the American Hospital Association. The new regulations provide that the hazardous location or areas in operating rooms will end at a height of 5 feet from the floor. This provision, it was explained, means that the ceiling hung operating rooms lights need not be explosionproof. It also means that non-explosionproof switches and outlets can now be used if they are located at a height of 5 feet or more from the floor. All portable equipment in the operating room must be explosionproof.

The new regulations are the result of more than three years of intensive study by the committee of the American Hospital Association and the National Fire Protective Association. The joint committee of the two groups was under the chairmanship of George Buck, administrator, University of Maryland Hospital, Baltimore.

Hold Course in Hospital Construction, Alterations

NEW YORK. — A special course in hospital construction and alterations got under way here last month under the sponsorship of the United Hospital Fund, the Hospital Council of New York and the Greater New York Hospital Association. Dr. John Gorrell of Columbia University's school of public health is director of the course, which offers evening classes once a week for 30 weeks in such subjects as rudiments of building design, functional planning, building materials, site selection, administrative considerations and specific design problems involved in various hospital departments and functions.

The faculty includes nationally known authorities in hospital administration, medicine, architecture and nursing. Tuition for the course is $60.

A PROVED SYSTEM OF IDENTIFICATION

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IDEAL FOR ADULT PATIENTS

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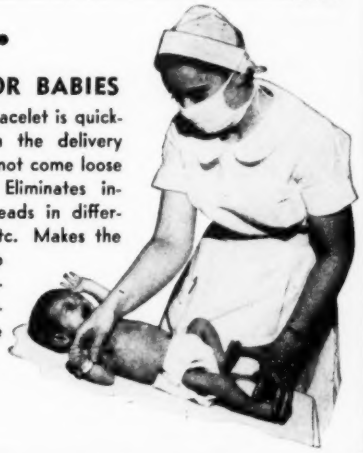

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NEWS...

Negro Applicant Refused Admission to Maryland School of Nursing

BALTIMORE, MD. — Admission to the University of Maryland School of Nursing was refused to a Negro applicant here by Judge W. Conwell Smith of the Baltimore City Court, who ruled that the applicant, 18 year old Esther McCready of Baltimore, could obtain equivalent training at Meharry Medical College, Nashville, Tenn., under an interstate agreement recently completed by a group of southern states.

In making his decision, Judge Smith concluded that "the state of Maryland has discharged its obligation in this single case in offering the training at the Meharry Medical College."

Attorneys for the plaintiff applicant said the decision would be appealed to the Maryland Court of Appeals and further if necessary.

The board of control for the interstate regional agreement explained that the program was not intended to relieve states of responsibility for providing education for all, but was rather aimed at providing "regional arrangements to supplement educational facilities within the states."

Attorneys for Miss McCready said the state's reliance on the regional agreement constituted "direct refusal of the state of Maryland to assume clear and constitutional obligations."

N.U. Alumni Group Elects New Officers

CLEVELAND.—Ninety alumni of the Program in Hospital Administration at Northwestern University attended the annual dinner and business meeting of the alumni association held here last month during the hospital convention.

The following officers were elected for the coming year: president, Eva H. Erickson, administrator, Galesburg Cottage Hospital, Galesburg, Ill.; president-elect, Hayden M. Deaner, administrator, Truesdale Hospital, Fall River, Mass.; vice president, Tracy Hare, consultant, Florida State Board of Health, Tallahassee, Fla.; secretary, Bessie Covert, the Modern Hospital Publishing Co., Inc., Chicago; treasurer, Ray M. Bolinger, assistant administrator, Robert Packer Hospital, Sayre, Pa.; director, Dan Brown, administrator, Los Alamos Hospital, Los Alamos, N.M.

NEWS . . .

House Passes Revised Social Security Act

WASHINGTON, D.C. — A bill revising the Social Security Act to include nonprofit institutions under the act's old-age benefit and survivors' insurance provisions was passed by the House of Representatives here last month. The bill was not expected to get consideration in the Senate until the new session of Congress convenes next January.

Under the revised act, as passed by the House, employes of nonprofit institutions, including hospitals, would be covered for old-age benefits and survivors' insurance on the same basis as other social security beneficiaries today if the employer elected to pay the employer's share of the tax. However, the bill provides that the employer may elect not to pay his share of the tax in which event the employe would receive only half the full retirement benefit.

Under the bill the taxable wage base for financing old-age benefits, survivors' and disability insurance would be the total annual earnings up to $3600.

Schedule Institutes on Planning and Personnel

CHICAGO.—An institute on hospital planning will be held at Cincinnati November 28 to December 2 under the sponsorship of the American Hospital Association, it was announced at association headquarters here last month. The institute is planned for hospital people interested in designing or constructing new hospitals or additions to existing hospitals.

A personnel administration institute to be held at Highland Park, Ill., December 5 to 10 will complete the educational activities for the year.

N.Y. Council Reelects Goetz

NEW YORK.—Norman S. Goetz was reelected president of the board of directors of the Hospital Council of Greater New York, it was announced here last month following the annual meeting of the council. Mrs. Adrian Van Sinderen, past president of the Visiting Nurse Association of Brooklyn, was reelected treasurer. Three new vice presidents were also elected: T. J. Ross of Ivy Lee & T. J. Ross, public and industrial relations consultants; Marian G. Randall, executive director of the Visiting Nurse Service of New York, and Dr. Morris Hinenburg.

NEWS...

Start Construction on Chronic Disease Hospital on Welfare Island

NEW YORK. — Construction was started last month on the new Bird S. Coler Memorial Hospital on Welfare Island, Dr. Marcus D. Kogel, city hospitals commissioner, announced. The 2000 bed hospital for chronic diseases is the second of three units for the care of long-term patients which will eventually designate Welfare Island as a medical center for the care and treatment of long-term cases, Dr. Kogel said. Future plans call for another 1500 bed hospital, 1000 beds for chronic and 500 beds for tuberculosis patients, on another island site.

Largest of its type in the city, the Bird S. Coler Memorial Hospital will care for both bed and ambulatory custodial patients, it was explained. The hospital will provide for many chronic cases now being cared for in the overcrowded services of municipal general care hospitals, and patients will also be transferred from the two homes for the aged and infirm now operated by the department of hospitals.

The hospital will be affiliated with the New York Medical School-Flower Fifth Avenue Hospitals, which will provide the professional staff, Dr. Kogel said. Completion of general construction is scheduled for November 1950 and occupancy for early in 1951.

"This hospital is planned as a replacement for the City Home for Dependents, which was opened in 1846," Dr. Kogel said. "Because of the desperate overcrowding of our municipal hospitals it will not be possible to close the City Home when this building is completed. It is intended to move into this building the 600 sick and infirm now at the Farm Colony on Staten Island and the bedridden custodial patients choking up the services of our general hospitals. Whatever space is left will be occupied by hospital patients now at the City Home. Close affiliation of this hospital with the medical school will ensure an active type of treatment, the best in rehabilitation services and a dynamic philosophy of care which will mark a milestone in the care and treatment of this type of patient."

Architects Plan Seminar on Hospital Design

BOSTON.—Chapters of the American Institute of Architects representing architects in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut are planning a seminar to be held here December 1 and 2 to discuss the proper design of hospitals, it was reported last month. The program will include topics of interest to hospital consultants, administrators and medical personnel as well as to professional architects, and it is expected that the discussions will attract representatives of all groups concerned with hospital design and construction, the announcement said.

Open House at Brooklyn

BROOKLYN, N.Y.—Twenty-one voluntary hospitals here participated in the first Brooklyn Hospital Sunday, October 9. The observance featured "open house" visits to all the hospitals, demonstrations of special phases of hospital work in the various institutions, and conducted tours aimed at giving the public a better understanding of the hospital facilities available in the community.

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ABOUT PEOPLE

(*Continued From Page* 88.)

William Kozma has been appointed assistant director, Southside Hospital, Bay Shore, Long Island, N.Y. Mr. Kozma, a graduate of the 1948 class in hospital administration, Columbia University School of Public Health, served his administrative residency at Nassau Hospital, Mineola, N.Y.

Harold Robert Cathcart has been appointed administrative assistant at Pennsylvania Hospital, Philadelphia, to work with **E. E. James,** assistant administrator. Mr. Cathcart completed the hospital administrative course at the University of Toronto and interned at Blodgett Hospital, Grand Rapids, Mich., and at Hillsdale Community Health Center, Hillsdale, Mich.

Dr. George T. Denny, chief of professional services in the Veterans Administration Hospital at West Roxbury, Mass., became manager of the hospital October 2, succeeding **Dr. John T. Bennett.**

Alexander Harmon has joined the staff of City Hospital, Cleveland, as assistant superintendent, **Supt. S. A. Ferguson** has announced. Mr. Harmon is a graduate of the hospital administration program of the University of Chicago and served his administrative internship at Stanford University Hospitals, San Francisco.

Dr. Linus A. Zink has been chosen head of the 1000 bed Fort Hamilton Veterans Administration Hospital, now under construction at Fort Hamilton, Brooklyn, N.Y. Dr. Zink has held administrative posts in the army and the Veterans Administration.

Lois Jones has been named supervisor of the Community Hospital, Newark, N.J., filling the vacancy created a year ago when **Romeo C. Gibbs** resigned to enter the hospital administration course at Columbia University. Mr. Gibbs is now an administrative intern at Freedmen's Hospital, Washington, D.C.

Department Heads

W. G. Messer assumed his duties as purchasing agent at University Hospital, Augusta, Ga., in October. He was formerly purchasing agent and administrative assistant at Providence Hospital, Mobile, Ala. Mr. Messer succeeds **O. S. Hilliard** who was recently appointed superintendent of Athens General Hospital, Athens, Ga.

Dr. Emanuel M. Papper has been named attending anesthetist and executive officer of the anesthesia service, Columbia-Presbyterian Medical Center, New York City, and associate professor of anesthesia, faculty of medicine, Columbia University.

Rev. C. O. Pedersen has retired as rector of Norwegian Hospital, Brooklyn, N.Y., after 30 years' service. He has been succeeded by **Rev. Frank M. Salvesen,** who was formerly associate rector.

Dennis Fennelly has been named employe relations manager of the Pennsylvania Hospital, Philadelphia. He was previously associated with the industrial relations department of the Glenn L. Martin Company, Baltimore.

Miscellaneous

Dr. Frederick W. Slobe of Chicago has been elected assistant director of the Illinois Blue Cross Plan for Hospital Care. He will direct the medical department, relieving **Dr. Frank P. Hammond,** who will continue to serve as medical adviser and will give attention to increasing demands of the Blue Shield Medical Service Plan.

Gen. George C. Marshall has been named president of the American Red Cross by President Truman to succeed **Basil C. O'Connor.** Mr. O'Connor resigned after serving for five years.

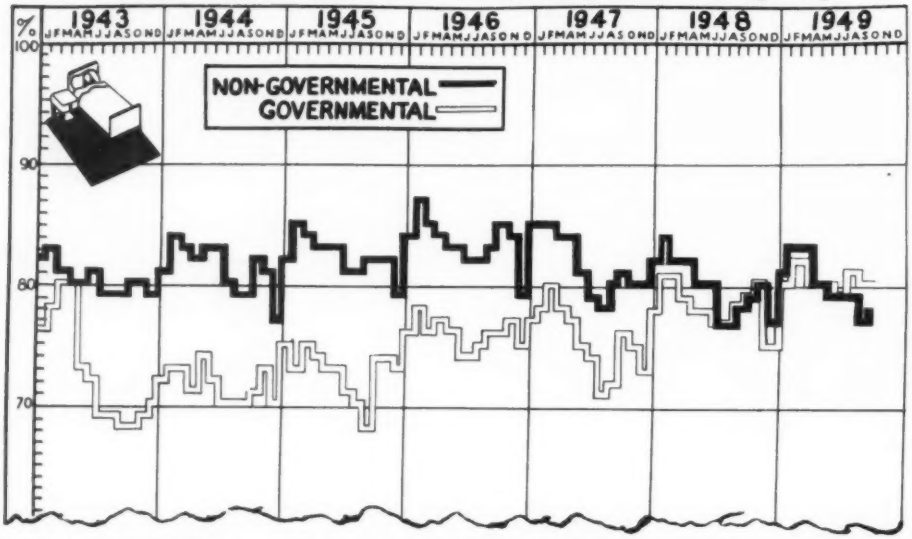
Dr. Harry S. Mustard will resign as New York City Commissioner of Health by the end of the year to become executive director of the State Charities Aid Association. Dr. Mustard has been health commissioner since 1947.

Dr. Lucius W. Johnson has resigned from the field staff of the American College of Surgeons. Prior to joining the college of surgeons, Dr. Johnson was an officer in the medical corps of the navy, retiring with the rank of rear admiral.

Deaths

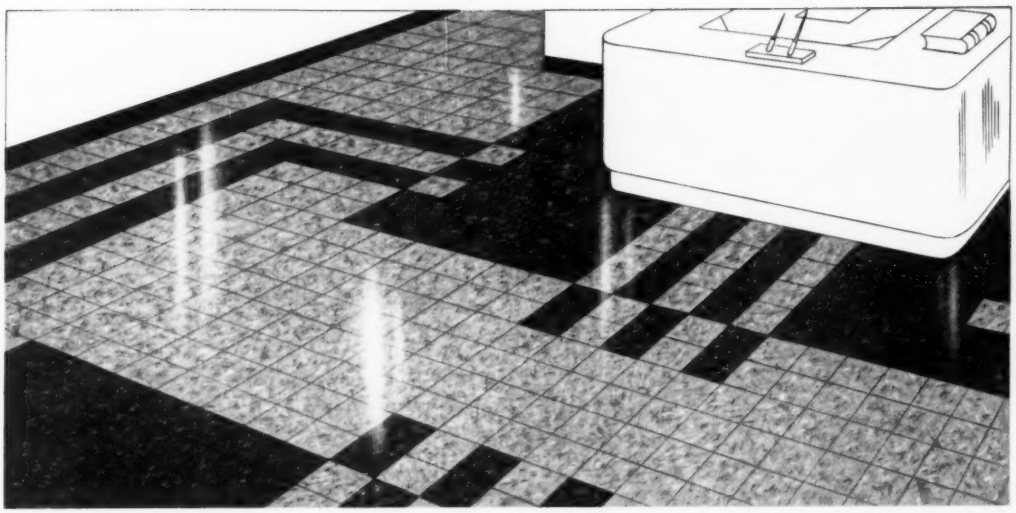
Herman Hensel, who served as superintendent of Presbyterian hospital, Chicago, from September 1942 to November 1945 and as assistant superintendent for 30 years, died on October 5 following a long illness. He was born in Chicago and was a graduate of Beloit College, Beloit, Wis. Prior to joining the administrative staff of Presbyterian hospital, he was on the faculty of Michigan State College in Lansing for three years.

Voluntary Hospital Occupancy Rises Slightly



Occupancy in nongovernmental hospitals increased slightly in September to 77.6, .2 per cent higher than the figure for August and .2 below the figure for September a year ago. Government hospital occupancy remained the same as in August, *i.e.* 79.8; this is 2.3 per cent above the occupancy reported for September 1948.

New hospital construction lagged behind that for September. Reports for the month totaled 43 projects, with 33 reporting an aggregate cost of $32,755,057. Of these, 18 were new hospitals, of which 13 reported costs of $16,481,800; 24 were additions to existing buildings, 19 of which cost $11,732,565.



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This is Armstrong's Linoleum. Moderate in first cost, it is an economical flooring buy because it gives long service even under heavy traffic conditions and because it costs so little to keep clean. Its wide range of colors and designs offer unlimited opportunities to create floors that add a cheerful atmosphere to both new and old interiors. It has a cushioning effect which makes it comfortable and quiet underfoot. Armstrong's Linoleum is made in six types—Plain, Jaspé, Marbelle®, Embossed, Spatter, and Straight Line Inlaid. Available in three thicknesses.

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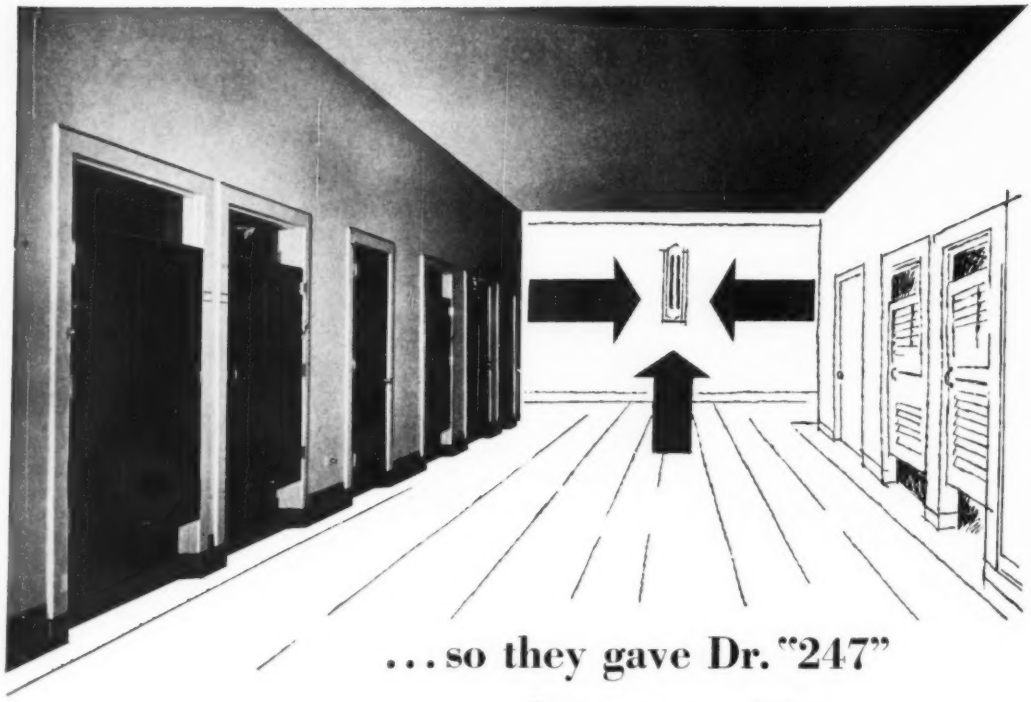

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It was just that Dr. 247 never seemed to be *on top of* the annunciator when his number was flashed. And how else could he be expected to see his number on one of those "ornamental," low-visibility affairs?

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A small detail, perhaps—but typical of the constant search Edwards conducts for refinements that will step up your administrative and personnel efficiency.

NEW PAGING ANNUNCIATOR INCREASES EFFICIENCY...

If you can see the annunciator, you can see the signals . . . it's as simple as that with this new Edwards' inverted "V" design. Flashing numerals can be seen front, left and right. At all times, visibility is clean and sharp, without any haze or cross-lighting.

Write today for free specifications bulletin on all Edwards Hospital Signal Systems.

Edwards Co. Inc., Norwalk, Conn.
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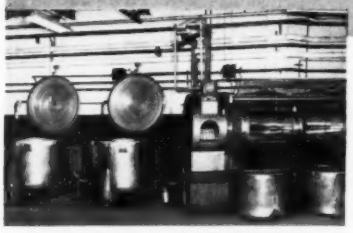
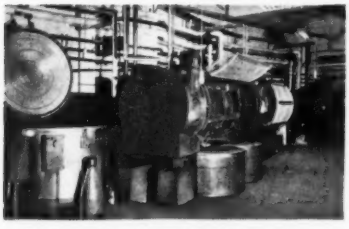
EDWARDS
HOSPITAL
Signal Systems

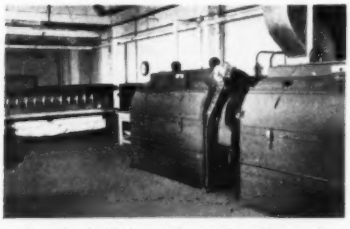
Since Temple University Hospital Modernized with HOFFMAN LAUNDRY EQUIPMENT



Two 50" unloading extractors (left) and central supply system (see controller stand at washer) provide fast, economical washing.



Three automatic 44 x 84 Shell-less Washers, elevated for faster dumpout, handle 350-pound loads on fast schedule.



Two 42 x 90 "Balanced Suction" tumblers and one 8-roll Chest Type flatwork ironer round out Temple's modernized laundry.

. . . 29% more linen is done
. . . in ½ the time
. . . with ½ the labor cost
. . . FOR ONLY 3¢ PER POUND

Including Direct Labor, Supplies, Water, Steam to Heat Water, and Electricity

TWO YEARS AGO, when the Temple University Medical School and Hospital, in Philadelphia, was considering general expansion, the need for improved laundry service was even then critical in the existing hospital. A survey made by U. S. Hoffman laundry engineers revealed a high turnover in laundry personnel — a six-day work week averaging 11 hours a day — generally inadequate facilities for processing Temple's 27,000 pound per week volume.

Modernization of the laundry, therefore, was made an integral part of the expansion program which Temple undertook last year.

With its new capacity of 600 beds, weekly laundry volume now stands at 35,000 pounds, including the work of student nurses and interns. Hoffman "Shell-less" washers and unloading extractors, along with Hoffman tumblers and flatwork ironer, are processing this 29% heavier volume for only 3c per pound. Hoffman equipment is credited with helping the Temple laundry staff to do "more work in eight hours than in sixteen in the old plant. Soap and other supplies have been cut almost in half — less linen discarded."

To find out how Hoffman equipment can do an equally effective job in reducing your laundry costs per patient day, write or phone for an engineering survey, without obligation, *today*.

U. S. HOFFMAN MACHINERY CORPORATION
107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

now take it Point by Point

Specify Columbia Window Shades — and you get everything you could ask of a shade, plus a name that's known and trusted by millions of users.

Specify COLUMBIA PYROXYLIN — and you get *more* of everything you want! It's a super shade, Columbia's best! Check it point by point!

Columbia Window Shades and Venetian Blinds are sold only through Columbia Authorized Dealers — leading department and furniture stores and shade shops. May we send you samples of PYROXYLIN Window Shades and the name of the Columbia Authorized Dealer nearest you? Write today.

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WINDOW SHADES AND VENETIAN BLINDS

ACTUALLY PAY A PROFIT! Pyroxylin shades, because they're top quality, wear longer than the usual shade life expectancy . . . allow low maintenance costs...actually make a profit for you, as one large user puts it.

CUT REPLACEMENTS—PYROXYLIN IS WASHABLE! Takes to actual scrubbing — repeated washings—fabric remains firm and sturdy, colors stay fresh. It's waterproof, too, to rain, steam, dampness.

FORGET PINHOLES OR CRACKS! Pyroxylin shades are made on such a closely-woven base, without filler, that they're impervious to cracks and pinholes. Better, *longer* wear!

COLOR SCHEMING — TAKE YOUR CHOICE! Match or harmonize Pyroxylin with any color plans...14 solid colors, including high-fashion pastels and decorator darks. Duplex combinations, also. Popular PRINTED shades.

VELVET-SMOOTH TO OPERATE! Columbia's shade rollers, made in Columbia's own plant, take care of that! Dependable, silent service throughout Pyroxylin's career.

PIGMY TO GIANT SIZES! Your Columbia Authorized Dealer will make these fine shades to your exact window sizes.

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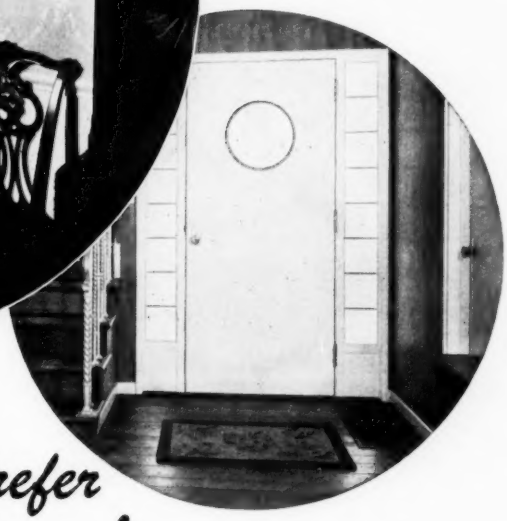

HOLLOW-CORE TYPE
embodying the famous, patented "INSULOK" grid core

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SOLID-CORE TYPE
permanently stabilized by unique slotted core-stock

Know the Facts And You Will Prefer

MENGEL *Flush* DOORS

Mengel Hollow-Core and Stabilized Solid-Core Flush Doors are designed, engineered and exhaustively tested to give *life-time* service. In both types, exclusive Mengel construction and curing processes provide utmost protection against warpage . . . hardwood stiles give maximum screw-holding strength and "take" stain, to match faces perfectly . . . keylock dovetails keep stiles and rails permanently tight . . . hot-press bonding assures virtually *everlasting* satisfaction . . . superfine belt sanding of faces and machine planing of edges reduce installation and finishing costs.

Mengel Flush Doors are the most dependable doors you can use, *yet volume manufacture in high-efficiency plants permits really competitive prices.*

The coupon below will bring you complete details. Mail it today, and *know* the facts.

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Plywood Division, Dept. MH-4, Louisville 1, Ky.

Gentlemen: Please send me a free copy of the complete Data Book on Mengel Flush Doors.

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Marble provides that quiet beauty and sanitary protection for which our modern hospitals are justly famous. The cool cleanliness of Marble floors and walls is symbolic of the sanitary safeguards built into every detail of hospital construction and equipment.

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more pleasant for your patients

Wash away room-clinging odors with a gentle flow of fresh, clean air. Bring to each bedside *controlled* ventilation . . . whatever the weather.

Swing-out vents of beautiful Fenestra* Intermediate Steel Windows sweep in passing breezes. Tilt-in vents shed rain outside and deflect drafts toward the ceiling.

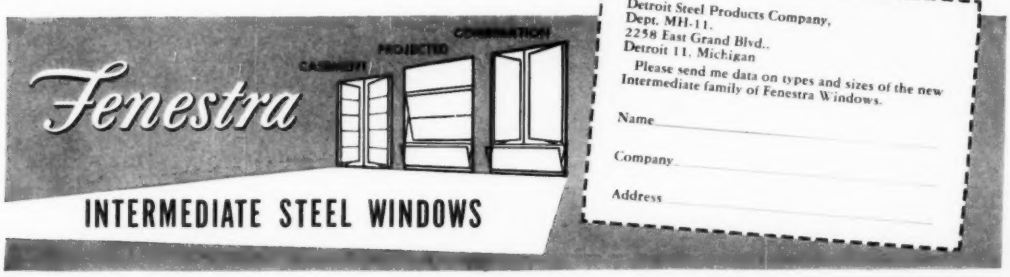
Patients like these graceful open-faced windows because through them they can see and feel more of the freedom of the outdoors.

Nurses like them because one gentle hand can operate the ventilators.

Maintenance men can screen and clean them from inside the room. And Fenestra Intermediate Steel Windows are well-made of fine steel sections by skilled craftsmen.

You'll like them because they're weather-tight, fire-safe, of fine appearance, economical.

Standardized production keeps a ceiling on the cost and uniformity in the quality. Installation costs naturally are lower with standard types and sizes. Build fresh-air and daylight into your hospital . . . economically. Mail the coupon for complete information. •®



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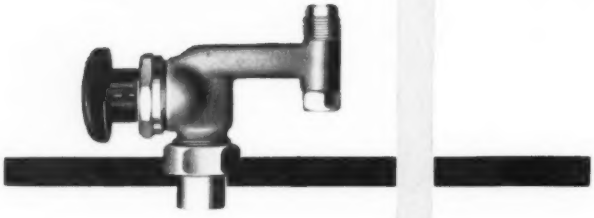

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prove their worth on every job!

increase operating efficiency . . . cut your costs

Dunham Fin-Vector Radiation is a case in point. These long, narrow, finned pipe heating elements are ideal for many installations where standard radiators are not suitable. They are light in weight but of unusual strength and heating capacity and are available with attractive covers.

Unique Dunham design enables the fins to be interlocked when pressed on to the pipe. This tight mechanical joint provides a permanent and greater contact area between fins and pipe . . . eliminates use of solder bond without sacrifice of heat transfer. Single pipe feature permits high, safe working pressures . . . absorption of sudden shock without injury.

Products Like These Help Dunham Vari-Vac* Heating Cut Fuel Costs Up to 40%

It's quality products like these that enable Dunham Vari-Vac Differential Heating to effect sensational fuel savings in Spokane's Davenport Hotel, the Rochester General Hospital and other well-known buildings all over the country.

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**Variable vacuum*

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HEATING MEANS BETTER HEATING

Scanlan-Morris has the word for...

TOPS IN AUTOPSY TABLES

A CORROSION-RESISTANT, long-lasting top of solid Monel is an important feature of this pedestal type Scanlan-Morris A-29 Autopsy Table. The table top is 76" x 30" and is provided with 5 perforated, removable Monel drainage sections. Friction lock holds headrest securely in desired position. Water supply valve is located at head end of table. Concealed piping and connections are readily accessible by means of a removable panel in the pedestal. The pedestal is of cross braced welded steel construction covered with a heavy gauge, Nickel-Chromium stainless steel jacket.

For autopsy tables — as for most major hospital equipment — one word guarantees quality.

And that word is MONEL*.

The usefulness of this silvery Nickel Alloy is due to a unique combination of properties, rather than to any single characteristic.

In Monel, for example, you have a metal that is completely *non-rusting*. In addition, Monel is stronger and tougher than structural steel. And its surfaces, being hard and smooth, are not readily marred or damaged.

Even after years of steady service, Monel equipment still looks new. *But this durability cannot be credited to Monel's strength and toughness alone.* Another point to keep in mind is that Monel is solid metal. There's nothing to chip or crack, nothing to peel off or wear away. Monel's durable surface, you might say, extends *clear through* the metal.

Naturally, nobody can scour away Monel's good looks. But why try? Monel resists corrosion and staining by acids, alkalis and dissecting solutions. Blood, tissue and other wastes are easily flushed off the smooth, polished surfaces. After that, you usually need nothing more than warm, soapy water to restore Monel's original satiny sheen.

Remember these characteristics. They work hand-in-hand to make your investment in *any* piece of Monel equipment a *sound* investment.

* * *

For further information about Scanlan-Morris Monel-equipped autopsy tables, write THE OHIO CHEMICAL & MFG. CO., 1400 E. Washington Ave., Madison 10, Wis.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

*Reg. U. S. Pat. Off.

EMBLEM OF SERVICE
INCO
TRADE MARK

MONEL* ...ALWAYS A WISE WORD TO REMEMBER

PRATT & LAMBERT
paint and varnish

"Slept in room just painted, with no discomfort"...

SO reports the head of a mid-western hospital, after Lyt-all Flowing Flat was used on the walls of the room, to test its freedom from the usual paint odor. As a result of this test, Lyt-all Flowing Flat is now used throughout for regular maintenance painting.

There are 100 years of experience back of the manufacture of Lyt-all Flowing Flat. Washing restores the original beauty of the 26 distinctive, wall colors and makes repainting unnecessary for a long time.

Solidex, a one-coat, ultra-flat OIL paint for walls, is also free from "painty" odor. The modern, authentic colors require no priming coat, but are ready for instant use.

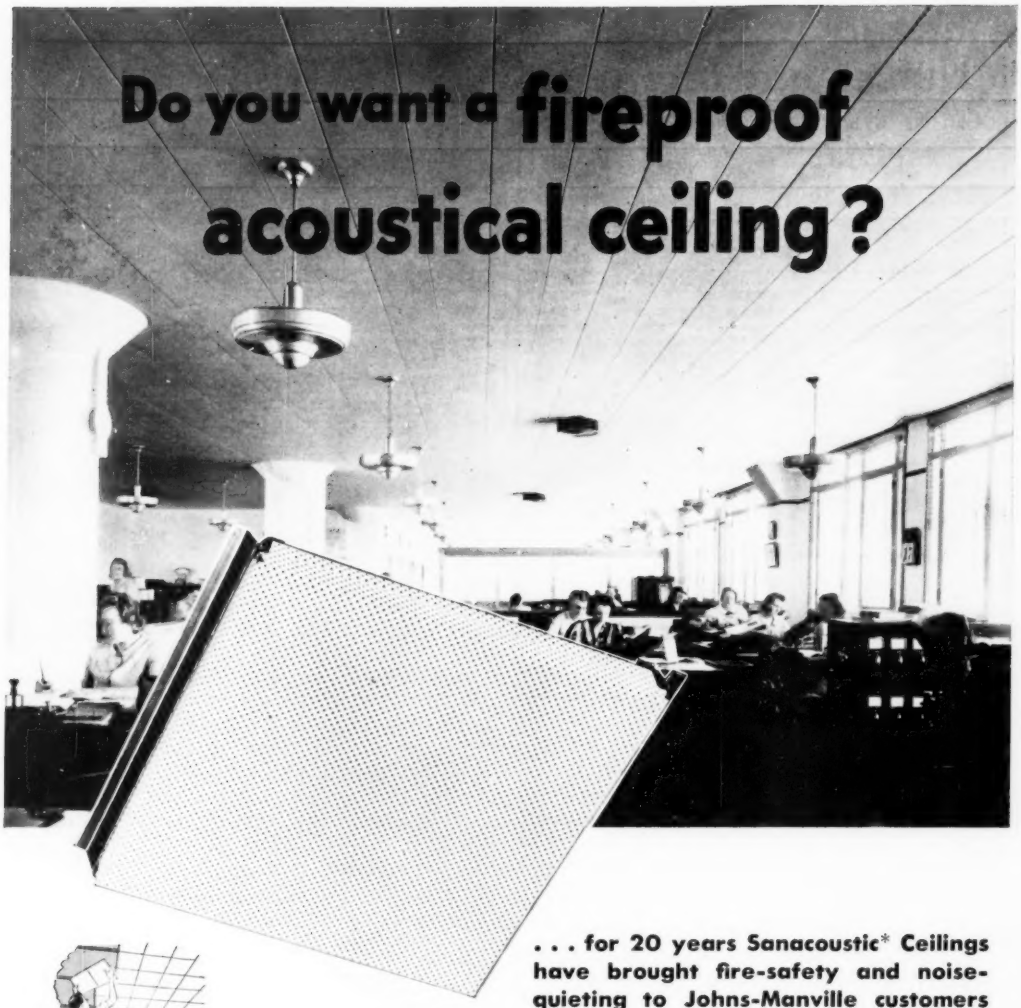
For decorative suggestions and practical painting specifications, write to Pratt & Lambert-Inc., 126 Tonawanda Street, Buffalo 7, N. Y. In Canada, 18 Courtwright Street, Fort Erie, Ontario.

1849 — One Hundredth Anniversary — 1949

REGISTERED PL TRADE MARK

Save the surface and you save all!

Do you want a fireproof acoustical ceiling?



Sanacoustic Units may be applied to new or existing ceilings. The method of installation assures perfect alignment, allows easy removal without damage.

An exclusive J-M patented construction system permits interchangeability of flush-type fluorescent lighting and acoustical ceiling units.

The attractive appearance of Sanacoustic blends with any interior. All-metal-and-mineral construction assures fire-safety.

. . . for 20 years Sanacoustic* Ceilings have brought fire-safety and noise-quieting to Johns-Manville customers

● Millions of square feet of J-M Sanacoustic Ceilings are serving in institutions, offices, and places of public assembly because they combine fire-safety with extremely high sound-absorption qualities.

Consisting of perforated *metal panels* backed up with a fireproof sound-absorbing element, Sanacoustic Ceilings will not burn, rot, or disintegrate. They combine the advantages of good appearance, removability, high light-reflection, and ease of maintenance.

Write for our new 16-page brochure, "Sound Control." Johns-Manville, Box 290, New York 16, N. Y.

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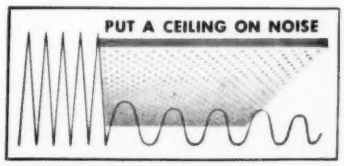
JM PRODUCTS

Johns-Manville

SANACOUSTIC CEILINGS



NOW—A WELDWOOD Flush Veneer Door with Solid Lumber Staved Core

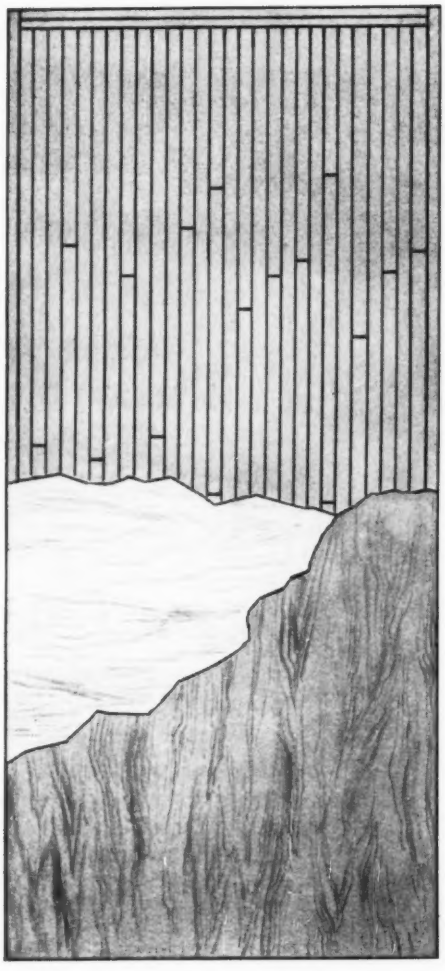


Figure on extra durability, utility, dimensional stability and modest cost when you include the WELDWOOD *Solid Lumber Staved Core* Flush Veneer Door in your plans.

* * * * * *

On your next job—you can plan on obtaining lifelong beauty and satisfaction by specifying this WELDWOOD Door, whether for interior or exterior use.

The Solid Lumber Core gives the door a real feeling of solidity. At the same time the door is substantially lighter than other doors of similar type. Available with face veneers of all the popular species, the WELDWOOD Flush Veneer Door gives you the rich beauty of real wood.

The thoroughly seasoned and kiln-dried basswood lumber laid on edge in staved construction makes the door dimensionally stable—no warping and twisting. And because 100% waterproof phenolic resin glue is used, the door is perfect for either interior or exterior use.

This WELDWOOD Door lends itself especially to cutting light or louvre openings in the field. Or you can obtain the door on order with the openings already prepared.

The addition of this Solid Lumber Staved Core Door complements the present line of popular WELDWOOD Flush Veneer Doors, including the *WELDWOOD Standard Door (with incombustible mineral core)* and the *WELDWOOD Fire Door* which carries the Underwriters' Class "B" Label. Write or contact our nearest branch for full information on the complete assortment of Weldwood Doors.

UNITED STATES PLYWOOD CORPORATION

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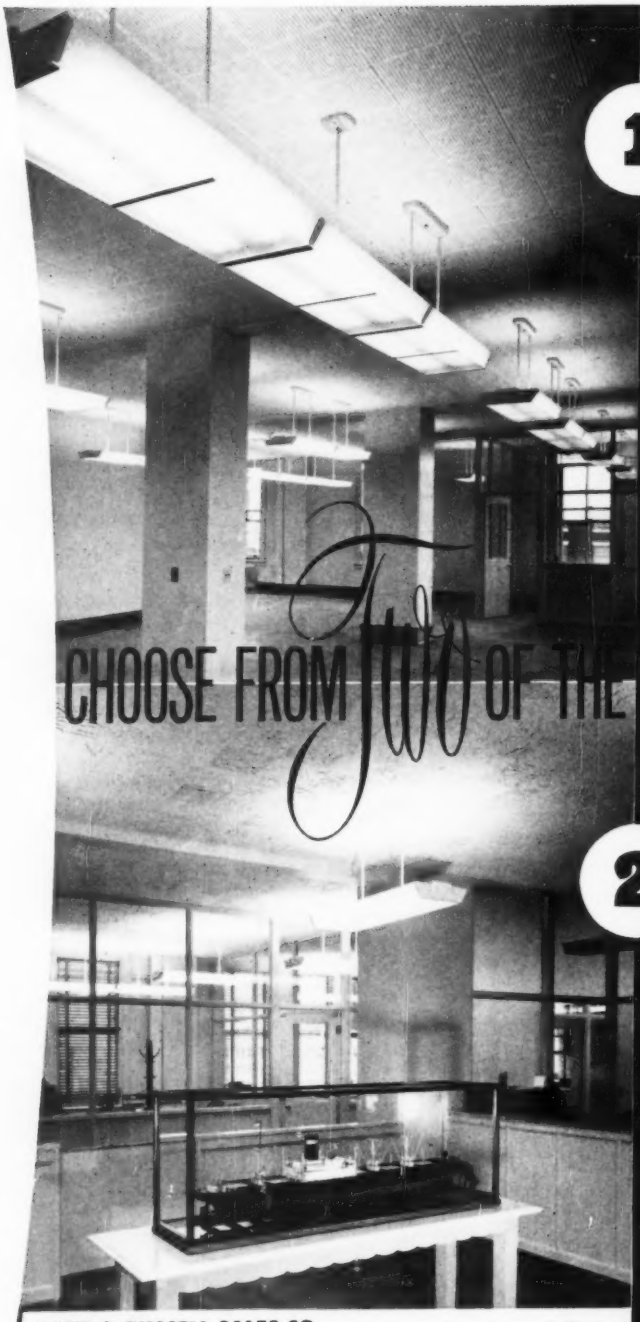
Distributing units in Albany, Baltimore, Boston, Brooklyn, Buffalo, Chicago, Cincinnati, Cleveland, Detroit, Fresno, Glendale, East Hartford, High Point, Indianapolis, Los Angeles, Milwaukee, Newark, New Hyde Park, N. Y., New York, Oakland, Philadelphia, Pittsburgh, Portland, Ore., Richmond, Rochester, San Francisco, Seattle, Spokane, St. Paul, Toronto. Also U. S.-Mengel Plywoods, Inc., distributing units in Atlanta, Birmingham, Dallas, Houston, Jacksonville, Kansas City, Louisville, New Orleans, San Antonio, St. Louis, Tampa. *In Canada:* United States Plywood of Canada, Limited, Toronto. Send inquiries to nearest point.



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PERFORATED ACOUSTICAL TILE

The serviceability, economy, cleanliness, paintability, and washability of Fir-Tex Perforated Acoustical Tile have made this type one of the most popular. Made of sound wood fibers, felted and pressed into rigid tile. Exposed surface perforated for maximum acoustical properties.

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INCOMBUSTIBLE ACOUSTICAL TILE

For sheer beauty, Dantore tile can be put at the top of the list. Its fissured travertined surface provides character and distinction as well as unexcelled acoustical properties. Being incombustible, Dantore tile is ideal for use in such public institutions and buildings as hospitals, schools, hotels, theatres, restaurants.

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Lily's* gaily decorated dessert cups are too good to save for holidays! Once you've actually tried them, you'll thank Lily for the money saved! But money isn't all — they save time, labor, washing, breakage, planning — you save many ways with Lily cups. They put staff and patients in a holiday mood, too, because they're so decorative — so light and easy to handle.

Try the economical Cranberry Velvet recipe above, and send for additional menu helps, plus a free trial supply of Lily cups. Prove to your own satisfaction that Lily's sparkle has a practical side.

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Efficiency and Economy of *GAS* Kitchen Important Factors in Hospital Operation

Providence Hospital, Beaver Falls, Pennsylvania
Sister Irenaeus, Superintendent

Two views of the compact GAS Kitchen, showing Chef Harry Ganoe who directs operations with the assistance of Mrs. Ganoe

EFFICIENT KITCHENS can save many a hospital operating dollar while contributing substantially to successful hospital management. In periods of peak occupancy these factors are especially important to food service executives and hospital administrators.

The demand for efficiency in volume food preparation is one of the reasons why Gas Equipment is specified in so many hospital expansion and modernization plans. Among dietitians and food administrators the merits of GAS are well-known, and the records of successful Gas Kitchens in hundreds of institutions can be readily obtained.

Providence Hospital, Beaver Falls, Pennsylvania, is one of those establishments in which GAS has been in continuous use since the founding in 1909. Through two successive expansions Gas Equipment has been chosen. During the latest construction, in 1946, hospital executives selected modern Gas Cooking Equipment to supplement existing facilities. In the staff cafeteria and the service kitchens the hospital uses the following volume cooking tools:

Four Ranges	One Vegetable Steamer
One Deep-fat Fryer	One Toaster
One Bake Oven	One Grill
One Stock Kettle	One Coffee Urn

Chef Harry Ganoe, whose experience was gained in restaurant and hotel service as well as in institutional kitchens, says, **"I've used Gas Cooking Equipment for many years and have always depended on GAS for volume food preparation. Efficient operation of our Providence Hospital Kitchen is my big job and the cleanliness and economy of GAS are mighty important factors."**

In every hospital or institutional kitchen there's a job for GAS and modern Gas Cooking Equipment. You'll find it worth investigating.

AMERICAN GAS ASSOCIATION

420 LEXINGTON AVENUE, NEW YORK 17, N.Y.

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NURSE REYNOLDS: Whew! That boy keeps me running. Wants everything at once. Thank goodness for Kellogg's Individuals. He loves 'em, and they save me so much time. I'd really be lost without them.

DIETITIAN LAMB: Naturally, we're careful about giving your child the right food. But it's important, too, to give him food he likes. That's why we go overboard on tasty, nutritious Kellogg's cereals.

GRAND NUTRITION: All Kellogg's cereals either are made from the whole grain or are restored to whole grain nutritive values of thiamine, niacin, and iron. Grand nutrition—*plus* Kellogg flavor!

Be sure your wholesaler salesman keeps your assortment of Kellogg's complete at all times.

Made by Kellogg's —THE GREATEST NAME IN CEREALS

Battle Creek and Omaha

Here's A Soup Service

THAT SOLVES EVERY SOUP PROBLEM!

1 Heinz Soups are made from the world's choicest ingredients, combined with homelike care and skill to produce the delicious flavors your customers *go for!*

2 Every one of the 12 kinds of Heinz Soups packed in 51-oz. tins has been carefully selected. According to a survey these 12 Heinz Varieties cover approximately 90% of the demand.

3 Heinz Soups in 51-oz. tins are easy to prepare and are ideal for fast, labor-saving service.

4 Heinz Soups in 51-oz. tins provide maximum convenience and enable you to serve without waste more kinds of soup than would otherwise be possible in the same place.

12 KINDS OF HEINZ SOUPS IN 51-OZ. TINS—Cream of Tomato • Bean Soup • Split Pea • Genuine Turtle • Cream of Green Pea Soup • Vegetable without Meat • Vegetable • Beef Noodle • Beef with Vegetable • Chicken Noodle • Chicken with Rice • Clam Chowder • Also Cream of Mushroom Soup in 29-oz. tins.

• Write for FREE recipe book, "Quality Recipes Using Heinz Condensed Soups." Address Hotel and Restaurant Division, H. J. Heinz Company, Pittsburgh 30, Pa.

57

80 YEARS OF FINE QUALITY ★

ASK YOUR HEINZ MAN ABOUT

HEINZ condensed SOUPS

Also compare advantages of other quality Heinz products such as Heinz Tomato Juice, Heinz Oven-Baked Beans and Heinz 57 Salad Dressing.

Short Cuts

TO BETTER FOOD SERVICE

Busy hospital dieticians appreciate the time-saving benefits of Dixie Cups and Containers when used regularly for food and drink service. Ideal for serving both hot and cold foods and drinks, Dixie Cups and Containers help speed portioning and distribution from kitchen to bedside. Paper keeps cold drinks *cold*, hot drinks *hot* — longer, and tight-fitting Dixie lids protect and hold foods at the peak of flavor and freshness until served.

DIXIE CUP SERVICE IS BETTER SERVICE BECAUSE IT'S...

SMOOTHER—Fewer delays in kitchen resulting from clutter of unwashed dishes or help absences. Fewer complaints resulting from beverages and foods reaching patients at distasteful temperatures.

QUICKER—Speeds distribution of bed-side meals and between-meal feedings—Dixies are always ready for instant use. Trays are lighter—less fretful waiting to be served.

QUIETER—No disturbing clatter of dishes by help or patients.

CLEANER—Used only once. Always fresh and appealing to eye and appetite.

SAFER—Constant protection of both patients and employees from mouth-borne infections.

THRIFTIER *Saves time, labor*—Greatly reduces dishwashing. Cuts clean-up, sterilizing, storing time by hours a day. *Saves food*—No waste through careless over-portioning. *Saves materials*—Less soap, detergents, hot water needed. No breakage, calling for constant replacements.

In hospital feeding the trend is to

DIXIE CUPS

MOST WIDELY ADVERTISED... MOST POPULAR OF PAPER CUPS

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DIXIE CUP

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COLD DRINK CUPS for fruit juice, tomato juice, etc.

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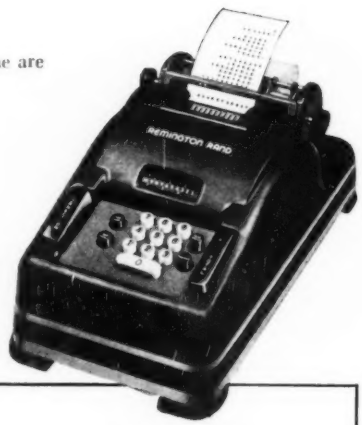
Numeral keys of this surprisingly compact electric adding machine are grouped scientifically—feature keys electrified; noise and vibration cushioned to an absolute minimum. Your seasoned operators automatically attain new high levels of touch method speed and accuracy—and beginners find their fingers expertly flying over the keyboard after a very short time.

But see for yourself. Phone our representative in your city or write for the free booklet "Cushioned Power" to Remington Rand Inc., Dept. MH-11, 315 Fourth Avenue, New York 10.



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You are—if you use Pacific Extra-Strength Muslins on your patients' beds. This man is just one of the many smart managers of hospitals across the country who have found these sturdy sheets to be a BIG economy!

They're soft, white muslins—wonderfully long-wearing, yet so low-priced. They're made Pacific's exclusive *balanced* way: no luxury qualities sacrificed to gain greater durability. No harsh muslins, these, to try your patients' patience!

Your distributor can supply you with Pacific Extra-Strength Muslins—order yours today.

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Sound hospital planning demands equipment of excellence in craftsmanship and service. The IBM Nurses' Call System has these qualities, and a world-wide organization to assure you the best in service.

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CARROM FURNITURE CRAFTSMEN *Build* FOR THE DECADES

Attractive, well-made Wood Furniture combines, to a high degree, both literal and figurative warmth and friendliness. From a practical, physical standpoint *wood*, because it is to a great extent a non-conductor of heat, has a friendly, comfortable "feel" that invites use. But over and above this . . . wood possesses a natural *emotional warmth* that is normally generated by intimate, friendly things.

Carrom Wood Furniture possesses, in a great measure, these characteristics of "Friendly Warmth" . . . appealing to the natural instincts of the average person. This is especially desirable for institutional use where the individual finds himself more or less remotely situated from home and friends. Both physically and psychologically, he enjoys the gracious and beneficial influence of "friendly warmth", generated by the ageless spirit and fibre of WOOD!

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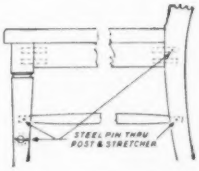

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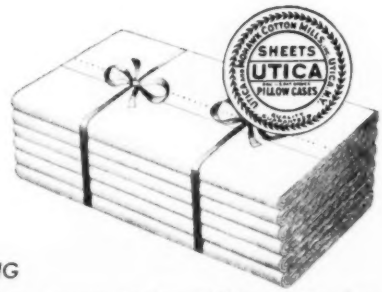

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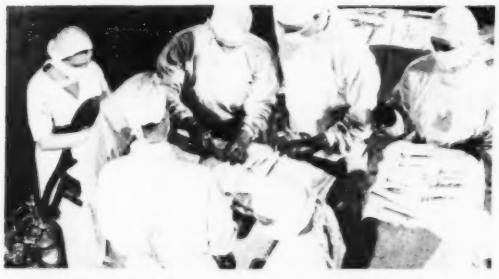

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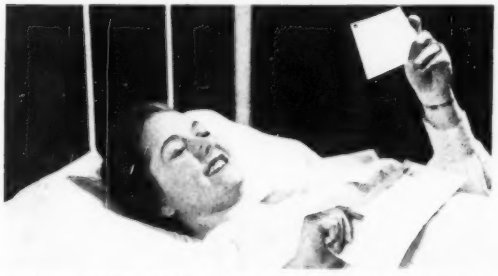

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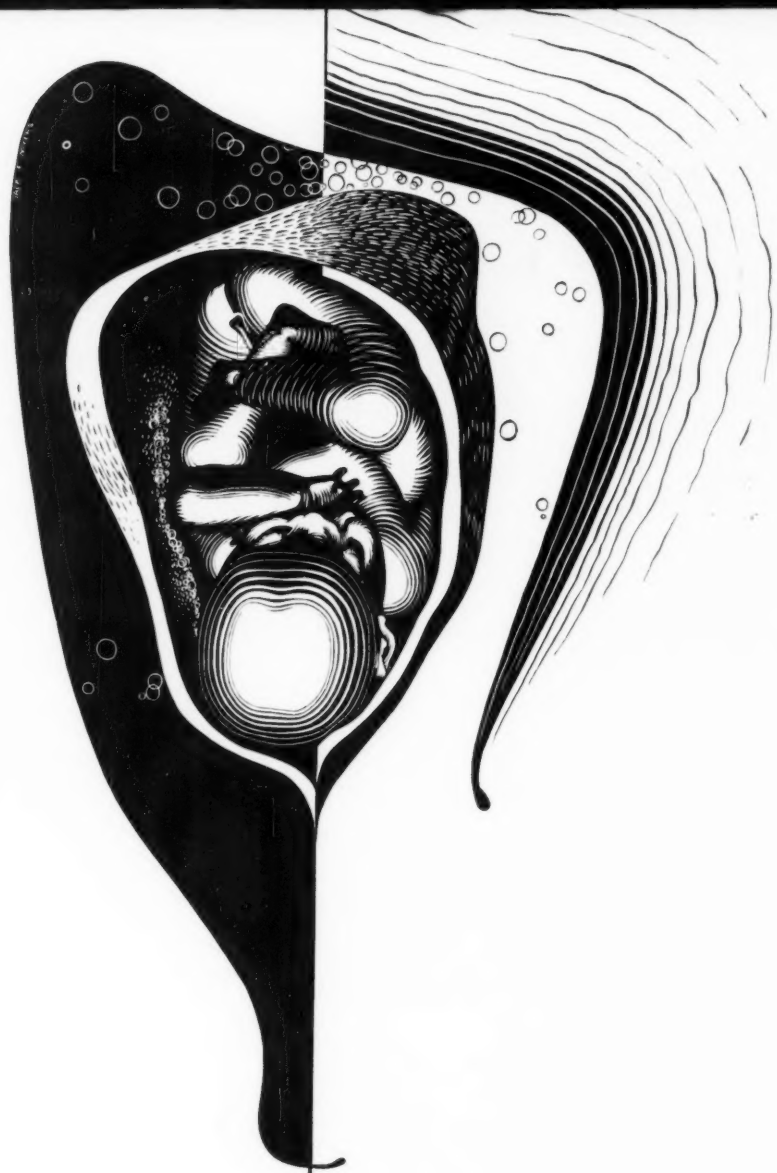

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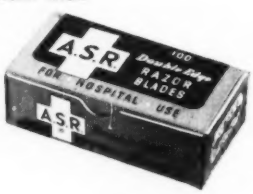

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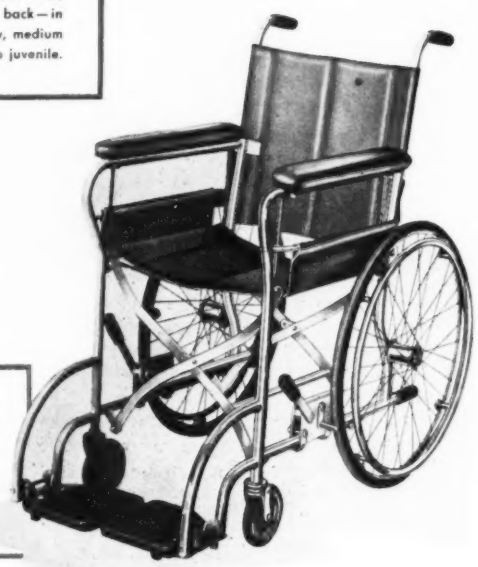

Model 4319—light and strong—the universal folding chair for combination outdoor and indoor use. Seat and back of plastic leather, padded with foam rubber for super-comfort. Model 4318 is recommended where wheel chair is to be used exclusively indoors.

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"Talc is a Dangerous Agent in its present use as a Surgical Glove Lubricant"[1]

SAFE SUBSTITUTE NOW AVAILABLE AT COST OF ONLY 2¢ PER OPERATION

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants.

All published studies agree that talc as a glove lubricant is unsafe. Animal experiments have shown the dangerous complications that follow talc implantation.

* * *

EFFECTS IN TISSUE

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

* * *

"Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments, and suture material, and by the air-borne route."[1]

* * *

SERIOUS COMPLICATIONS

"The frequency of such contamination is attested by the increasing number of case reports of serious complications due to talc. Animal experiments show that the granulomatous reaction can be regularly produced in the peritoneum, pleura, pericardium, muscle, joint, nerve and tendon."[1]

FOREIGN BODY REACTION

German[2,3] found intra-abdominal granulomata which he proved came from foreign body reaction to talc in 40 out of 50 unselected patients subjected to a second laparotomy.

* * *

Seelig[4,5] repeatedly demonstrated the danger of talc in mice, which are notably resistant to the production of adhesions, by injecting 2cc. of a 5% saline suspension of the powder intraperitoneally, and has stated that "the average surgeon cannot possibly perform this experiment and ever afterward face talcum powder with equanimity."

* * *

REPLACEMENT

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, with a small amount of magnesium oxide added. It is treated physically and chemically to assure good lubrication after sterilizing.

* * *

COMPATIBLE WITH TISSUE

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O.R. technics. Costs less than 2 cents per operation. Bio-Sorb has been used over two years in several hundred hospitals. Complete literature mailed on request.

* * *

SAFETY CONFIRMED

The findings of Lee and Lehman[6] that Bio-Sorb is safe have been confirmed by Lindenmuth[7] and MacQuiddy.[8] Postlethwait et al[1] concluded that "talc is a dangerous agent in its present use as a surgical glove lubricant," and stated that "a modified starch powder (Bio-Sorb) which is absorbed with little or no reaction is again suggested as a satisfactory substitute for talc."

* * *

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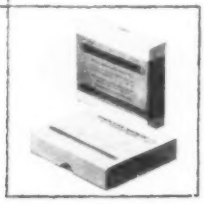

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The importance of the two-circuit UniTrane room units with their independent control of room temperature, room humidity and ventilation air is shown by direct comparison with earlier attempts to achieve this ideal arrangement.

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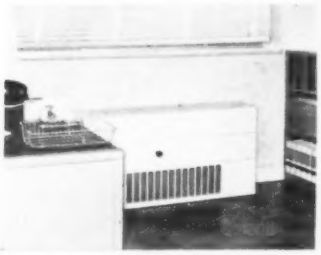

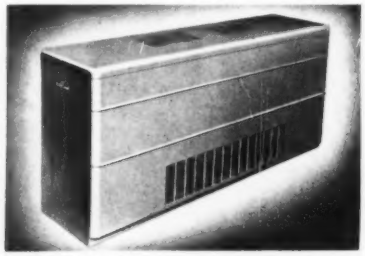

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(Continued on page 216)

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DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIRECTOR OF NURSES—Assistant; for 110-bed hospital; east; degree required; salary open. MO 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Applications are invited for the position of Director of Nurses for the Royal Columbian Hospital, New Westminster, British Columbia; nearly completed addition to the hospital brings total bed capacity to approximately 412; New Westminster, a thriving city with a population of about 34,000, is located just 12 miles from Vancouver; duties consist of directing nursing services and accredited school of nursing with approximately 140 students; teaching degree and administrative experience required; salary range $4200 to $4800 per annum; applicant must be Canadian citizen; please reply fully giving details of age, education, training and experience to the Director, Royal Columbian Hospital, New Westminster, British Columbia, Canada.

DIRECTRESS OF NURSING Jewish General Hospital, Montreal, Canada; a hospital with a 15 year record of progressive development requires directress to organize and administer Canada's most modern training school and residence, now under construction; applicant must have background and proven ability to develop a training school of the top rank and to direct the hospital's nursing service; this is an unusual and challenging opportunity for one who has a genuine interest in nursing education and the ambition to do a really creative piece of work. Address, The Superintendent, Jewish General Hospital, 3755 Cote Street, Catherine Road, Montreal 26, Quebec.

INSTRUCTOR Clinical; for 100-bed hospital; east; college credits required; salary open. MO 64, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 218)

HOSPITAL SUPERVISOR—Chief for female admission and medical and surgical services; experience in psychiatric nursing necessary; 40-hour week; 2 weeks' vacation; 10 legal holidays; basic salary $3000. Apply, Director of Nurses, Taunton State Hospital, Taunton, Massachusetts.

INSTRUCTOR Clinical; surgical floors, teach pharmacology; preparation and experience required. Associate Director, School of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTOR—Clinical; for general hospital of 200 beds situated on a crest of Blue Ridge Mountain, one mile south of Ashland, Pennsylvania; requiring B.S. Degree in Nursing Education and at least one year teaching experience; salary open; two weeks' vacation, 15 days' sick leave granted if required. For information write Barney W. Wentz, Superintendent, Ashland State Hospital, Ashland, Pennsylvania.

INSTRUCTOR—Nursing arts; for New England hospital with approved school of nursing; 200 beds; degree necessary; salary compatible with experience and preparation. Newport Hospital, Newport, Rhode Island.

INSTRUCTOR—Obstetric clinical; 5-day, 40-hour week; two weeks' paid vacation; liberal sick leave; salary open. Apply, Director of Nurses, Saint Francis Hospital, 900 Hyde Street, San Francisco 9, California.

INSTRUCTORS—Nursing arts; also 2 Clinical instructors in surgery; for a collegiate nursing program; salary open. Apply, Chairman, Division of Nursing, Dillard University, New Orleans 19, Louisiana.

Want Advertisements

POSITIONS OPEN

LAUNDRY MANAGER—Experienced; wanted for 250-bed hospital in northern Ohio; send references. MO 60, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

LIBRARIAN—Medical record; need not be registered, but able to install standard nomenclature; stenographer preferred; 63-bed modern hospital; good salary, plus full maintenance. Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

LIBRARIAN—Medical records; registered record librarian for position at Hospital for Sick Children, Toronto; give experience and references. Apply to Superintendent, 67 College Street, Toronto, Ontario.

LIBRARIAN—Record; trained; to open and organize a department of records; state salary expected. Apply Superintendent, Trail-Tadanac Hospital, Trail, British Columbia.

MISCELLANEOUS—Immediate opening for night Supervisor; 20-bed hospital; must be qualified to take care of obstetrical cases and delivery room; general floor duty; help available when duties are heavy; 48-hour week; hours 11 P.M. to 7 A.M.; salary $200 per month with 1 meal; also opening from 3 P.M. to 11 P.M.; general floor nursing; salary $185 per month with 1 meal. Write Cameron Community Hospital, Cameron, Missouri.

MISCELLANEOUS—Matron and Registered nurses; 3; for modern 20-bed hospital; salary, $175 and $145 with full maintenance. Write or phone E. W. Groshong, Porcupine Carragana Union Hospital, Porcupine Plain, Saskatchewan.

MISCELLANEOUS—Superintendent of nurses; $395 to $481 a month; psychiatric nursing instructors; $310 to $376 a month; positions offering challenging opportunities for service and initiative in California state hospitals; college degree, psychiatric nursing experience and eligibility for California license required. Write today for further information to Recruitment Section (N9), State Personnel Board, 107 State Building, San Francisco 2, California.

NURSE—Trained; to take over night duty; between the age of 35 and 45; salary with maintenance, $2400 a year. Address, T. C. Simon, Administrator, Mount Pleasant, Reisterstown, Maryland.

NURSES—Full or part-time assignments; opportunities for progressive experience in general hospital near university; special surgical program; convenient living quarters and food service in residence hall. Address, Director of Nursing, Mount Sinai Hospital, Cleveland, Ohio.

(Continued on page 220)

NURSES—Graduate; for 475-bed hospital; salary open. Apply, St. Barnabas Hospital for Chronic Diseases, 183rd Street & 3rd Avenue, New York 57, New York.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Head; for New England hospital with approved school of nursing; advanced preparation necessary; salary compatible with experience and preparation. Newport Hospital, Newport, Rhode Island.

NURSES—Obstetrical, general duty and delivery room scrub nurses; salary starting at $200; additional for delivery room, evening and night duty; pleasant working conditions. Apply, Directress of Obstetrics, Methodist Hospital, 506 Sixth Street, Brooklyn 15, New York.

NURSES—Operating room; two; for 80-bed general hospital; active surgical service; minimum beginning salary $185 with meals and laundry; 45-hour week; liberal personnel policies; new 180-bed general hospital under construction. For further details make application to Director of Nursing Service, 1407 Janes Avenue, Saginaw, Michigan.

Want Advertisements

POSITIONS OPEN

NURSES—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

NURSES—Supervisor and General duty; for new 14-bed hospital; small Texas Panhandle town; salaries open. Apply Business Manager, Floyd County Co-operative Hospital, Lockney, Texas.

NURSES—Supervisory, operating room and obstetric; $275-$325; staff nurses $230-$270; 40 hour week; excellent climate. Los Alamos Hospital, Los Alamos, New Mexico.

PHYSIOTHERAPIST—Experienced; wanted to open new department in fully approved 250-bed general hospital in northern Ohio. MO 59, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

RESIDENCIES — Anesthesiology; fully approved; clinical and didactic instruction in all phases of anesthesia; university affiliation. Apply, Administrator, Evanston Hospital, Evanston, Illinois.

SUPERVISOR OF NURSES—Assistant; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

SUPERVISING NURSES—One assistant superintendent of nurses, one service supervisor; both fine spots for nurses interested in nursing service administration; modern, well-equipped 192-bed plant; fully staffed nursing division; large intern-resident program with AMA and ACS approvals; separate medical and surgical services; excellent housekeeping and other supporting services; progressive personnel program includes 44 hour week, two weeks annual vacation, cumulative sick leave, position classification and pay plans, retirement plan; Wayne University nursing college and cultural advantages of Detroit, 25 miles by convenient public transportation; applicants should have considerable experience in nursing, and some experience in supervision; college work leading toward a degree in nursing administration; salary $246-278 per month, depending on position for which qualified, with regular merit increases. Apply Personnel Director, Pontiac General Hospital, Pontiac, Michigan.

SUPERVISORS—For medical and surgical nursing, wards; medical and surgical nursing, private; large general hospital; administrative duties only; degree and experience preferred, overall cash salary depends upon qualifications. Apply, Superintendent of Nurses, Cooper Hospital, Camden 3, New Jersey.

SUPERVISOR—Pediatric; for New England hospital with approved school of nursing; advanced work required; salary compatible with experience and preparation. Newport Hospital, Newport, Rhode Island.

SUPERINTENDENT OF NURSES—For the Madison County Tuberculosis Sanatorium, Edwardsville, Illinois; salary $275 per month and complete maintenance; pension plan in operation. Address, Loren L. Collins, M.D., Superintendent.

AMERICAN HOSPITAL BUREAU
C. M. Powell, R.N., Director
705 Carnegie Hall
Cleveland 15, Ohio

ADMINISTRATORS—(a) Large New England hospital, requiring well prepared man. (b) New hospital in California; qualified to equip, and organize services. (c) New hospital in midwest; state initiative and experience required. (d) New hospital; west coast.

ANESTHETISTS—(a) Medical anesthetist; 800-bed hospital; west coast. (b) 160-bed hospital; New England. (c) Nurse; 350-bed hospital; Pennsylvania. (d) 500-bed hospital; southern state. (e) 375-bed; New England. (f) Several small hospitals throughout the country.

DIRECTORS OF NURSING—(a) Approved school, university hospital; New England. (b) Approved school; 200-bed hospital midwest. (c) Large psychiatric hospital; South America. (d) University hospital; southern state; organization work. (e) 50-bed psychiatric hospital; Ohio. (f) New hospital; Texas.

FACULTY—(a) Educational directors; (b) Instructors, sciences, nursing arts, clinical, special services; excellent positions; good salaries.

(Continued on page 222)

POSITIONS OPEN

AMERICAN HOSPITAL BUREAU
—Continued

SUPERVISORS—Operating room; obstetrics; orthopedics; communicable disease; pediatrics; psychiatry; tuberculosis; medical-surgical.

DIETITIANS — Administrative; therapeutic; teaching; many openings everywhere.

LIBRARIANS—Qualified to set up new departments, re-organize others.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

ANESTHETISTS—(a) California; clinic hospital; closed staff; $335; very satisfactory working conditions. (b) Western Washington; 125-bed hospital employing four anesthetists; $300. (c) Oregon, 125-bed hospital; no obstetrics; employing five anesthetists; $300. (d) California, catholic hospital; 100 beds; $300; 40-hour week; southern area.

ANESTHETIST-SUPERVISING NURSE — Small well-equipped Nevada hospital; $325 with maintenance plus extra fees for administering anesthetics; comfortable living quarters, good meals.

BUSINESS AND MEDICAL REGISTRY
—Continued

DIRECTOR OF NURSES—General hospital of 75 beds, Los Angeles area; $300; 40-hour week; small and well-furnished house available on hospital grounds at nominal rental.

DIETITIANS—(a) Administrative; large protestant church hospital; southern California city; $275; 40-hour week. (b) Therapeutic; 500-bed county hospital; southern California; $246; 40-hour week.

OCCUPATIONAL THERAPY TECHNICIAN—Home for spastic children, delightfully located in foothills above one of California's most noted seaside resort cities; $200-$250, depending upon experience.

OBSTETRICS — (a) Obstetrical supervisor; post-graduate course and supervising experience; small but busy department of 45-bed general hospital; industrial town suburban to Los Angeles and near ocean; $235, maintenance. (b) Obstetric nurse for small new district hospital near California coast and south of San Francisco; $250; 40-hour week; position open for January first.

OFFICE NURSE—To assist busy general practitioner in small town 150 miles northeast of Los Angeles; doctor will teach x-ray; $250; living accommodations readily available.

NIGHT SUPERVISOR—Take entire charge of house; 500-bed county hospital 30 miles from Los Angeles; 40-hour week; $280.

BUSINESS AND MEDICAL REGISTRY
—Continued

PRACTICAL ARTS INSTRUCTOR — County hospital; 500 beds; agricultural section of California near coast; $280; 40-hour week.

PHYSIOTHERAPY TECHNICIAN—Office of busy medical group located in small central California inland town; $250.

MEDICAL RECORD LIBRARIAN—Able to take charge of department; 75-bed hospital in Los Angeles area; $250; maintenance available at hospital at reasonable charge; 40-hour week.

TUBERCULOSIS NURSES—General staff positions open in 165-bed county hospital in mountains, 30 miles from southern California city of 75,000; daily transportation furnished to city for cultural and recreational advantages; $235, full maintenance; 40-hour week, 11 holidays annually, liberal vacation and sick leave.

SURGERY NURSES—(a) County hospital; 100 beds; San Joaquin Valley northeast of Los Angeles; $262 for 40-hour week; $5 extra for each call. (b) Small new district hospital near California coast and north of Los Angeles; $250; 40-hour week; position open for January 1st.

SUPERVISORS—Three; one day, one afternoon and one night; small private general hospital, southern California metropolitan area; positions require nurses with supervising experience; $250-$260; 40-hour week.

(Continued on page 224)

Want Advertisements

POSITIONS OPEN

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 60-bed Ohio hospital; 40-bed addition planned. (b) 100-bed hospital, Kentucky; school of nursing. (c) 65-bed eastern hospital, modern; new wing under construction. (d) 50-bed new hospital, Illinois.

ASSISTANT ADMINISTRATOR—(a) 225-bed New England hospital; ideal situation; adequate salary; residence provided; accounting or business management experience desired. (b) 85-bed hospital, Virginia. (c) 100-bed hospital, southwest.

SUPERINTENDENT—(a) Graduate nurse; 50-bed hospital, north central state. (b) 45-bed hospitals, Montana, Iowa, Colorado, Kentucky, Ohio, New York; $300.

DIRECTOR SCHOOL OF NURSING — (a) Splendid opportunity in large hospital; university city, mid-west; modern buildings and educational unit; salary open. (b) 500-bed hospital, west coast; $6000. (c) 250-bed hospital; school has collegiate affiliation; south. (d) 225-bed hospital; suburb New York. (e) 200-bed hospital, east; $5000. (f) 150-bed Illinois hospital.

INTERSTATE HOSPITAL—*Continued*

DIRECTOR, NURSING SERVICE—(a) 185-bed hospital; southern Wisconsin. (b) 100-bed hospital; Michigan; high nursing standards. (c) 325-bed Ohio hospital; $350, maintenance.

EDUCATIONAL DIRECTOR—(a) 275-bed midwestern hospital; $325, maintenance. (b) 200-bed New Jersey hospital; (c) 250-bed Massachusetts hospital; $275. (d) 175-bed hospital, Texas; $300.

RECORD LIBRARIAN—(a) 300-bed Ohio hospital. (b) 220-bed Wisconsin hospital; $200, maintenance. (c) 240-bed hospital; eastern city.

DIETITIAN—(a) Administrative; 300-bed hospital; Pennsylvania; $325, maintenance. (b) 300-bed tuberculosis sanatorium; mid-west. (c) Therapeutic; desirable localities; to $250, maintenance.

HOUSEKEEPERS—(a) 100-bed hospital; New York. (b) 300-bed hospitals; Tennessee, Kentucky, Carolinas. (c) 150-bed hospitals; Masschusetts, Michigan, Pennsylvania, Ohio.

PHYSIOTHERAPISTS — (a) $200-$250. (b) Technicians; laboratory; $200-$300. (c) X-ray; $175-$225.

(*Continued on page 226*)

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ACCOUNTANTS—(a) Chief; 300-bed hospital; east. (b) To reorganize and direct department, large general hospital; Pacific Coast. MH11-1

ADMINISTRATORS—(a) Medical and assistant medical administrators; hospital group affiliated with university medical school; middle western metropolis. (b) Lay, large general hospital, municipally operated; Master's Degree in Hospital Administration desirable; west. (c) General hospital, 150 beds; college town of 25,000, east. (d) Lay; teaching hospital of more than 400 beds; middle west. (e) Voluntary hospital considered one of the leading in its state, 300 beds; considerable charity work; east. (f) Medical; municipal hospital, 500 beds; university town; south. (g) Lay; general hospital, 60 beds; building program will double capacity; preferably someone available soon so as to assist with building program; residential town, 25,000, middle west. (h) Assistant medical administrator; university group, more than 1200 beds. (i) Woman physician to direct general hospital, 200 beds; unit of university group. MH11-2

NURSE ADMINISTRATORS—(a) Small hospital now under construction; capable organizer required; small town, middle west. (b) Small general hospital; summer resort town, Michigan. (c) Small general hospital; winter resort town, Florida. (d) Convalescent home for crippled children; will be completed early 1950; college town, south. MH11-3

Want Advertisements

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Fairly large hospital located few miles from several large cities, including university center; eastern seaboard; $3700, increasing to $4500. (b) Well equipped hospital in Hawaii; beautiful location; $3600, maintenance; transportation from west coast refunded after year's service. (c) Fairly large hospital; San Francisco area; $4300. (d) New hospital beautifully located in Alaska; $300-$350 maintenance; transportation from Seattle. MH11-4

DIETITIANS—(a) Chief; university hospital of 500 beds to be increased to 950 within five years; capable organizer required; $4200-$5000. (b) Assistant dietitian; should be qualified to take charge of nurses' dining rooms and pay cafeteria serving 1000 meals daily; university town, east. (c) Nutritionist; university appointment; duties consist of serving as consultant; middle west. (d) Chief, general hospital; hospital recently opened under American auspices in South America; knowledge of Spanish desirable. (e) Dietitian; home economics department, large food manufacturing company; should be experienced in quantity food cooking, qualified to develop recipes for hotels, institutions; should have fairly wide interest in writing; duties involve some traveling; $5000-$6000. MH11-5

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) One of the leading private hospitals in the middle west; 300 students, faculty of 14; excellent teaching affiliations. (b) Modern hospital, 350 beds, medical staff conducts program approved by American Boards; should be qualified to establish and conduct post-graduate program for nurses; university center. (c) Beautiful new hospital of small size; all-graduate staff; suburban and college town near Chicago. (d) One of leading hospitals in California; well staffed faculty; $6000. (e) Collegiate school now being established in connection with large hospital; Master's Degree desirable; large city, Pacific Coast. (f) Of entire service; university hospital, 500 beds; east. (g) Director of nursing service only; hospital and clinic now under construction; units of university medical center; outstanding opportunity; west. (h) Assistant director of nursing service; teaching hospital; delightful location, completely furnished private suite provided in beautiful new apartment building, middle west. MH11-6

EXECUTIVE SECRETARY — Professional counseling and placement service being developed by state university; duties include some traveling. MH11-7

FACULTY APPOINTMENTS—(a) Educational director; unit of university group, large city of the east, university center; $4000. (b) Science instructor; one of the leading hospitals in eastern metropolis; $3600. (c) Clinical and nursing arts instructors; teaching hospital; school now being established; living accommodations consist of furnished suites in beautiful new apartment building; middle west. MH11-8

(Continued on page 228)

MEDICAL BUREAU—*Continued*

FOREIGN APPOINTMENTS—(a) Two surgical nurses and, also, assistant director of nurses; hospital conducted under American auspices in Peru. MH11-9

MEDICAL RECORD LIBRARIANS—(a) Small general hospital, well organized department; college town, California. (b) Assistant; hospitals and clinics connected with university medical school; west. (c) Chief; large teaching hospital; east. (d) Chief; large teaching hospital; staff of two assistant librarians, 30 other employes. MH11-10

PHARMACISTS—(a) Large general hospital, leading city of United States dependency. (b) One of leading hospitals in Chicago area. (c) Chief; 300-bed hospital, university town, east. MH11-11

PURCHASING AGENT—Voluntary hospital of fairly large size; Pacific Coast. MH11-12

SUPERVISORS—(a) Obstetrical; general hospital operated in connection with eminently successful group clinic; resort area of the southwest; altitude 7500 feet; all recreational facilities; $275-$350. (b) Operating room; general hospital, medium bed capacity; college town of 50,000, short distance from Chicago; $275, maintenance, increasing to $300 after six months. (c) Outpatient department, averaging 6400 visits annually; expanding facilities; staff of six assistants; New York state. (d) Pediatrics; new hospital; college town, $4000. (e) Psychiatric; hospital now under construction on university campus, teaching center; middle west. MH11-13

Want Advertisements

POSITIONS OPEN

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
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ANESTHETIST—335-bed eastern university city; 8 anesthetists employed, minimum on call duty; excellent salary and living conditions.

DIETITIAN—Small hospital, winter resort city; $250, maintenance.

DIRECTOR OF NURSES—(a) 100-bed Michigan; graduate staff; $3600; meals and laundry. (b) Assistant; 150-bed Illinois; starting $3900.

EDUCATIONAL DIRECTOR—New university project; appointment will carry university faculty status; major portion of time to be spent in the field, directing program.

EXECUTIVE HOUSEKEEPER—300-bed leading hospital, with an extensive building program under way; attractive living quarters.

GENERAL STAFF—150-bed California; starting $235, complete maintenance; 40-hour week.

INSTRUCTORS—Clinical; nursing arts; science; 40-hour, 5-day week; $300.

RECORD LIBRARIAN—200-bed Wisconsin; 120-bed Massachusetts; 200-bed Connecticut.

MEDICAL PERSONNEL—*Continued*

SUPERVISORS—Operating room; New York; pediatric; Pennsylvania; night; Maryland; salaries high.

PHYSIOTHERAPIST—Head; new department; 260-bed hospital; starting $300.

OCCUPATIONAL THERAPIST—Children's hospital; starting $200; meals and laundry.

PHARMACIST—125-bed Pennsylvania; 25-bed addition being completed; salary open; maintenance.

TECHNICIANS—(a) Laboratory; 115-bed, Pennsylvania; $250, meals. (b) X ray; large hospital, Chicago; starting $225; meals.

PHYSICIAN—Resident; 100-bed general hospital; starting $350, including family maintenance.

We make no charge for registration

PHELPS OCCUPATIONAL BUREAUS
M. B. Phelps, Director
232 U.S. National Bank Building
Denver, Colorado

ANESTHETISTS—(a) General hospital; Wyoming; $375. (b) General hospital; Colorado; $300. (c) General hospital; Arizona; $375.

DIETITIANS—(a) Therapeutic dietitian; California; 5-day week; $310. (b) Dietitian; large city, Texas; salary open; other positions open in Florida, Arkansas and New Mexico.

Continued on page 230

PHELPS—*Continued*

LABORATORY X-RAY TECHNICIANS—(a) Laboratory x-ray technician; small hospital, mountainous country, Wyoming; maintenance and $200. (b) Registered laboratory technician; Washington; full charge, $325; other positions open North Dakota, Oregon and Nebraska.

GOVERNMENT HOSPITAL PERSONNEL—(a) New Mexico hospital; Medical record librarian, $346; (b) Medical stenographers, $279; (c) Supervisory and clinic nurses to $346. (d) General duty nurses to $340.

PHARMACIST—Montana hospital; male or female; eligible for registration, Montana; $300.

ASSISTANT SUPERINTENDENT—Will act as director of nurses; no training school; Oklahoma hospital; $300; similar positions Texas and Arkansas.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATOR—East; 90-bed general hospital; require good experience in public relations with both press and general public; $6000 to start.

ASSISTANT ADMINISTRATOR—East; 150-bed general hospital; it is a closed hospital with a staff of 13 doctors, all specialists; prefer someone who has just finished his training; house available, rent free.

Want Advertisements

POSITIONS OPEN

SHAY—*Continued*

PERSONNEL DIRECTOR—South; 320-bed general hospital; will consider man or woman with good background in hospital personnel; town of 60,000; 381 employes; $6000.

ASSOCIATE DIRECTOR OF NURSING EDUCATION—Middle west; 320-bed hospital, new, modern, well equipped; school of nursing fully accredited; B.S. Degree required; $4200 plus 2 room apartment.

DIRECTOR OF NURSES—Middle west; college town of about 30,000; 160-bed general hospital; not too much experience required; $375 plus maintenance.

ANESTHETIST—Middle west; 125-bed hospital; town of 40,000; easily accessible to Chicago; $350 plus full maintenance.

DIETITIANS—(a) Administrative; California; complete charge of dietary department; $350. (b) Chief; east; 283-bed hospital; $325, maintenance. (c) Assistant; east; 250-bed hospital; $250, maintenance. (d) Chief; Florida; ideally located in winter resort area. (e) Head; middle west; 184-bed hospital; completely new kitchens and dining room; $300 plus maintenance including newly furnished apartment. (f) Therapeutic; middle west; average daily number of therapeutic diets is 18-20; 265-bed general hospital; $225 maintenance.

SHAY—*Continued*

EDUCATIONAL DIRECTOR—Southeast; 65-bed general hospital; modern classrooms and teaching equipment; B.S. Degree required and some experience.

SUPERVISOR—Operating room; middle west; 200-bed hospital; not on call at any time, week ends free; $275 plus maintenance.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS—(a) Medical; important medical center; three units; 400 beds fully approved for residencies in the specialties; large southern winter-summer resort area. (b) Lay; one of the southeast's finest teaching hospitals; 400 beds. (c) Medical or lay; 90-bed maternity hospital; good record of public relations essential; New York area; $6000; excellent increases assured. (d) Lay; male or female; 30-bed general; now building 25-bed addition; beautiful New York summer resort community 5000; death occasions vacancy. (e) Modern, beautiful equipped 52-bed; under construction; only hospital in county; excellent salary for superior individual; central.

WOODWARD—*Continued*

ASSISTANT ADMINISTRATOR—(f) Medical; outstanding opportunity in one of the northeast's finest fully approved hospitals; 900 beds; requires someone not less than three years out of medical school; excellent future potential; carefully investigated; highly recommended; $5000 initially.

RADIOLOGIST—(g) 135-bed hospital completing 100 additional beds 1950; 20 staff doctors; 5500 diagnostic, 1400 therapies last year; only x-ray department in fine city 20,000; 50% of net equals approximately $12,000 now; can be greatly increased; central.

PATHOLOGIST—(h) 200-bed university hospital; also faculty appointment; $12,000; may also engage in private practice and will be able to join local pathologist with down town laboratory; important northwest medical center metropolis.

ANESTHETIST—100-bed hospital pleasantly located university campus southern resort town; $4200 yearly (N413)

CHIEF DIETITIAN—$4200 yearly; new ultra-modern hospital located southern capital adjacent university. (N601)

DIRECTOR OF NURSES—$5000 minimum; 200-bed approved hospital; outstanding educational program; well-staffed faculty; south Atlantic Coast. (N573)

EXECUTIVE HOUSEKEEPER—140-bed hospital; new and modern; college town; south. (N180)

MEDICAL RECORD LIBRARIAN—200-bed approved hospital; $225 to $275; opportunity for advancement; northwest. (N252)

(Continued on page 232)

Want Advertisements

PLACEMENT BUREAUS

BROWN'S MEDICAL BUREAU (Agency)
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New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

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Spokane 8, Washington

Many Good Positions in All Medical Specialties in the Great Northwest

Write us for full details.

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Anne V. Zinser, Director
Suite 1004—79 West Monroe Street
Chicago 2, Illinois

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MISCELLANEOUS

AGENT

Chicago area agency for repeat sale product in medical, hospital and or institutional trade. Now in 16th year of successful activity and can handle additional product. Dependable sales effort, warehouse and delivery facilities, excellent references and financial responsibility. Interested only in a good product with a good firm, on a mutually profitable basis. MW 72, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

BOOKBINDING

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Continued on page 234

MANUFACTURER'S REPRESENTATIVE

Wanted by established chemical manufacturer to handle a fast-selling industrial aerosol insecticide designed specifically for hospitals. Write Virginia Smelting Company, Department 60, West Norfolk, Virginia.

MARK and COMPANY

10B South 18th Street, Philadelphia 3, Pennsylvania, announces the establishment of a department to serve woman's organizations, particularly auxiliaries seeking larger income. Full details without obligation, upon request.

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400 East 59th Street, New York City

Want Advertisements

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The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:
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Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

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SCHOOL FOR LABORATORY TECHNICIANS
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(Title 39, United States Code, Section 233)

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Sworn to and subscribed before me this 23rd day of September, 1949.

[SEAL] J. P. McDERMOTT, Notary Public.

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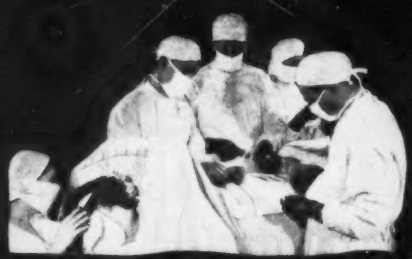

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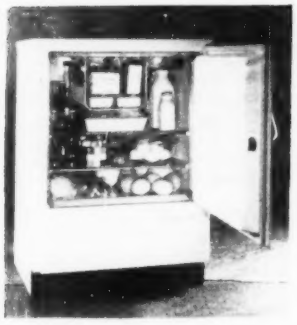
What's New for Hospitals

NOVEMBER 1949 Edited by BESSIE COVERT

Undercounter Refrigerator



An undercounter, 4 cubic foot refrigerator for installation in diet kitchens, utility rooms and other areas with limited space has been introduced by Westinghouse. The small unit is designed to fit under standard height sink drainboards and kitchen counter surfaces and requires only 24 inches of space. The refrigerator includes a small freezer for holding frozen food and has two 14 cube ice trays. **Westinghouse Electric Appliance Div., Dept. MH, Mansfield, Ohio. (Key No. 1)**

Non-Allergenic Gloves

The B. F. Goodrich Company is offering a type of surgeons' gloves which has proved non-irritating to surgeons allergic to the repeated wearing of rubber gloves. Known as "Special Purpose" surgeons' gloves, the new gloves are the result of extensive research and investigation and they are offered under the "Miller" brand. They are identified by a green wrist roll and green branding and are available in half sizes, 7 through 9. **The B. F. Goodrich Co., Sundries Div., Dept. MH, Akron, Ohio. (Key No. 2)**

Plastic Asphalt Tile

A resilient plastic asphalt floor tile known as Arlon has been announced as combining a monochromatic concept of coloring with high resistance to oils, greases, fats, alkali and wear. It is made from a combination of plastic and asphaltic compounds in $\frac{1}{8}$ and 3/16 inch gauges and in 9 by 9 inch tile. It is available in 11 shades, the pastels and muted tones of the patterns being blended to eliminate sharp contrasts. Each pattern has a base color with which a slightly lighter and a slightly darker tone are combined to provide an almost plain color effect while concealing foot prints and marks which would be more quickly noticeable on a plain color floor. **Armstrong Cork Co., Dept. MH, Lancaster, Pa. (Key No. 3)**

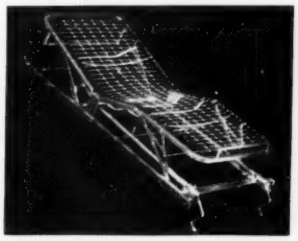
Static Detector

An electronic device that immediately detects the presence of static electricity in the operating room is now available. Known as the Lorhan-Webster Staticator, the device sets up an audible warning signal when static is present.

The machine is simple in design and operation, giving a persistent buzzing sound as the warning signal. The Staticator is small and compact and is designed to be placed on the gas machine or in any other location near the anesthesiologist. Antenna wire from the device is attached to the mask of the patient. Ground wires are attached to the gas machine and to the operating table. When any moving object produces a static charge, the warning signal is given. It is sufficiently loud to be heard

by the anesthesiologist but is not distracting to the surgeon. The machine bears the seal of approval of the Underwriters' Laboratories, according to the manufacturer, and it operates without maintenance or servicing. It is manufactured by W. E. Anderson, Inc. and distributed exclusively by **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 4)**

Versatile Two Crank Spring



Simmons has developed a redesigned two crank spring which permits lowering of head and foot ends of the spring below the horizontal level. This makes it possible to place patients in Trendelenburg, hyperextension, high sitting and improved sitting positions in their own beds by merely turning the cranks.

Known as the L-146, the new spring rises above the frame to permit lowering of head and foot ends. A patented spring release control simplifies lowering of the head section which is done by means of a crank with a minimum of effort. Beds equipped with the new L-146 provide general and specialized service without special equipment. The flexibility of the new spring makes every part accessible for easy cleaning. It can be used on all Simmons bed ends except full panel styles and is finished in triple-coat aluminum. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 5)**

Portable Oxygen Carriers

The Speed-O-Two portable oxygen carrier is designed to facilitate administration of therapeutic gases in difficult locations quickly and efficiently. Sturdily constructed, the carrier is light in weight and easy to move. A metal cover protects valve and regulator and aids in maintaining cleanliness. A shelf is provided inside the carrier for hose and face mask plus extra equipment. A handle on the cover and two roller bearing wheels make it easy to move. The body of the carrier is constructed of 22 gauge steel, aluminum finished. The carrier base is a one piece aluminum casting incorporating axle housing, cylinder well and leg rests. **The Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie Ave., Chicago 23. (Key No. 6)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Noiseless Typewriter

The Remington Noiseless Deluxe is a new typewriter finished in two-toned gray and incorporating a number of improvements and refinements over previous models of noiseless typewriters developed by the company. New features include: a completely enclosed dustproof back; structural members, carriage ends and rear comb of die-cast aluminum; feed rolls of softer-surfaced neoprene rubber for better paper gripping; closer tolerance, and improved machining of various integral parts. **Remington Rand Inc., Typewriter Div., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 7)**

Plastic Base Coving

A new Vinyl plastic set-on-base coving for use with all hard surface floors, such as rubber, asphalt tile and linoleum, has recently been announced. It is available in lengths of 100 feet in one piece and is 4 inches high. The length permits average installations to be made without seams and without the necessity for preformed corners. The coving can be adhered to any type of wall with ordinary floor covering adhesives and has a high gloss finish which does not catch dirt readily and which can be easily cleaned. **Fremont Rubber Co., Dept. MH, 105 McPherson Highway, Fremont, Ohio. (Key No. 8)**

Standardized Boilers

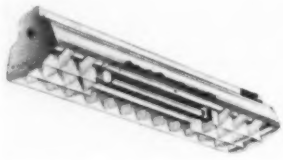
A series of six new standardized water tube boilers in the Springfield Type M line which are especially designed for coal firing with standard stokers but can also be readily adapted to oil or gas firing without any major change in the installation has recently been announced. Sizes ranging from 7500 to 17,000 pounds per hour steam generating capacity are available. All parts are externally supported for simple erection and easy accessibility. Standardization of dimensions for various sized units is a feature of the new line. **Springfield Boiler Co., Dept. MH, 1999 E. Capitol Ave., Springfield, Ill. (Key No. 9)**

Antiseptic Detergent

Developed especially for hospital cleaning, "First" Antiseptic Liquid Detergent contains a new germicide which is compatible to the cleaning agent and which is said to reduce bacteria count radically, to eliminate odors, mold and mildew and to clean thoroughly at the same time. It leaves no odor and is designed for cleaning surgery, nursery, kitchen, bathrooms and isolation rooms. It is already mixed with the proper proportion of cleaner to germicide, and cleans all types of floors with a minimum of labor. **Piatt & Smillie Chemicals, Inc., Dept. MH, 2329 Pine St., St. Louis 3, Mo. (Key No. 10)**

Sunlighter Fluorescent Fixture

A sun lamp as well as two light lamps are included in the new Leader Sunlighter fluorescent fixture. The light covers large areas and stays cool to the touch. It is said to reproduce the desirable mid-ultraviolet wave lengths of



sunlight known as the 2800 to 3200 Angstrom band. Thus the light is designed to provide the equivalent of sun rays while producing light without heat. It is suggested for installation in solariums, classrooms, offices and many other locations in the hospital. **Leader Electric Co., Dept. MH, 3500 N. Kedzie Ave., Chicago 18. (Key No. 11)**

Double-Action Floor Wax

Kare-33 is being introduced to serve two purposes in floor maintenance—to give floors a high gloss wax finish and at the same time to aid in the control of insects. This liquid water-emulsion wax has been approved by Underwriters' Laboratories, according to the manufacturer, for anti-slip properties. It is non-inflammable, non-combustible and water-resistant and dries to a high luster in 20 minutes without buffing. It is said to kill insect pests within 24 hours and to retain its insecticidal quality for 3 to 6 weeks. The product is designed for use on asphalt tile, linoleum, rubber, finished wood, mastic, cement, terrazzo, painted surfaces and cork floors and is packed in 1 gallon cans and 5, 30 and 55 gallon steel drums. **Windsor Wax Co., Inc., Dept. MH, Hoboken, N. J. (Key No. 12)**

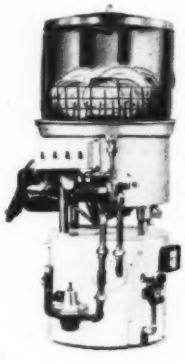
No-Gear Peeler

The new Blakeslee No-Gear Peeler is vertically designed with the motor mounted in the base and protected from damage and moisture. A sink-high, 4 position door permits direct discharge of vegetables into the sink. The abrasive side-wall and peeling disc are designed for fast, efficient peeling. The new model is designed for more efficient and quiet operation, easier maintenance, streamlined appearance and to save floor space because of the vertical construction. The machine is available in 3 new models, each finished in Duco or in stainless-clad construction. **G. S. Blakeslee & Co., Dept. MH, 1844 S. Laramie Ave., Chicago 50. (Key No. 13)**

Dishwasher-Boiler Unit

The new Jackson Combination Dishwasher-Boiler is designed to provide a constant supply of 180 degree hot water to ensure effective cleaning of dishes. A gas-fired boiler is an integral part of the combination dishwasher-boiler and produces hot water to meet the needs of the dishwasher. The boiler is built into the machine in such a way as to take up no additional floor space and it is easily connected with the gas line. Fitted directly under the dishwasher itself, the boiler is thoroughly insulated, is equipped with thermostat control and pressure and relief safety valves, heats water as it is used and is economical in operation.

Known as the Jackson Model 1-AB, the dishwashing section is identical with the 1-A machine. A revolving hood on the unit permits straight-through operation or corner installation. The unit is available with the Jackson automatic timer if desired. The new boiler may be fitted into 1-A dishwashers already in use to convert them to combination dishwasher-boiler units where desired.



The Jackson Dishwasher Co., Dept. MH, 3703 E. 93rd St., Cleveland 5, Ohio. (Key No. 14)

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Magic-Swivelock Casters

Wheeled equipment can be pushed quickly, safely and easily by one person, in a straight line along narrow corridors, and around sharp corners, without zig-zagging, with the use of the new Magic-Swivelock Casters recently introduced. The new casters are designed for use on stretchers, tray trucks, food trucks, linen carts and other wheeled equipment to make their propulsion in a straight line simpler.

Only two Magic-Swivelock Casters are needed for each piece of equipment, installed one at each end, according to the manufacturer. When the attendant pushes the equipment the leading caster locks instantly and automatically. While the other casters may swivel, the locked caster keeps the equipment in line. Corners are easily turned as the equipment pivots on the leading caster. A slight push against the side of the equipment instantly releases the lock so that the cart or stretcher may be moved sideways when desired. The Magic-Swivelock Casters operate automatically, regardless of which end of the equipment is pushed. **Jarvis & Jarvis, Inc., Dept. MH, Palmer, Mass. (Key No. 15)**

Floor Machine

The Johnson's Wax Super 16 is a heavy-duty chrome plated all-purpose floor machine made to handle any type of floor maintenance job. Besides polishing and scrubbing, the Super 16 may be used to sand, steel wool, grind and wax floors of all kinds and can be used with a solution tank and shampoo brush to shampoo rugs. Quick change accessories are available for each job.

The ¾ h.p. compact induction type motor is enclosed in a heavy aluminum casting, finished in chrome plate. Smooth operation is assured by the uniform distribution of weight over the brush area

and patented finger springs keep the machine level under any floor conditions. **S. C. Johnson & Son, Inc., Dept. MH, Racine, Wis. (Key No. 16)**

Labseal

Labseal is a new apparatus designed for sealing ampules in single or quantity production. It is a crossfire assembly with fishtail burner, simple to operate because of its flexible design and construction. Two-way clamps provide for adjustments of height, inclination and distance between burner tips. **PerfeKtum Products Co., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 17)**

Conference Top Desk

A new steel desk recently developed by Yawman and Erbe and known as the Conference Top Desk is now in production. Designed to provide maximum working space, the molded top of the desk extends out, thus providing knee space for those around it when it is used for conferences.

The desk has a top measurement of 78 by 39 inches exclusive of sliding shelves. Overhang at each end is 9 inches with the same amount of extension across the front. The molded top is linoleum covered with brushed

chrome metal insert caps on the corners and continuous chrome binding around the edge. One card and one vertical letter drawer are provided on each side of the desk and the adjustable glides permit optional height adjustments of from 29 to 30¼ inches. The desk has iridescent Neutra-Tone Gray finish with white metal hardware. **Yawman and Erbe Mfg. Co., Dept. MH, Rochester 3, N. Y. (Key No. 18)**

Guardian Safe

A new safe, suitable for holding papers and valuables in the office and designed to protect them from fire, theft and malicious damage, has been announced by Diebold. Known as the Diebold Guardian Line, the new safes carry the Class "C" tested fire rating from the Underwriters' Laboratories and Safe Manufacturers' National Association and comply with the U.S. Bureau of Standards' specifications, according to the manufacturer. A three-tumbler, key-changing combination lock secures the door and permits resetting the lock to any desired combination should it seem advisable with changes of personnel. **Diebold, Inc., Dept. MH, Canton 2, Ohio. (Key No. 19)**

Hydraulic Bedlifter

Beds can be lifted with a minimum of exertion with the new Zimmer Bed-Lifter recently announced. Made mostly of aluminum and weighing but 13 pounds, the bedlifter is easily operated by moving a plunger-handle up and down. It has a lifting range of 18 inches and lifts up to 1000 pounds smoothly and firmly without difficulty. It can be operated with one hand by a nurse or other attendant. The device takes up little room when not in use and is easily moved to place of need by rolling on its casters. **Zimmer Mfg. Co., Dept. MH, Warsaw, Ind. (Key No. 20)**

Refrigeration Equipment

Especially developed for use in hospitals and other institutions are the new commercial refrigerators recently announced by Frigidaire. Designed by Raymond Loewy, the cases are finished in white with free-flowing lines and chromium trim. The cabinets are constructed of heavy gauge steel with welded over-lap joints sealed to keep out moisture and interiors are finished in white porcelain with acid-resistant panels.

The new 44 cubic foot reach-in refrigerator is equipped with a new forced air cooling unit, has an improved, sealed and self-oiling Meter-Miser compressor in a small ventilated space below the food compartment, has three full length doors equipped with rubber seals and shelves which can be adjusted to satisfy individual requirements. The new 17 cubic foot refrigerator of the ice-making type can store up to 56 pounds of frozen food in the freezing compartment, is equipped with Quickube trays which will freeze 84 ice cubes or 12 pounds of ice and have automatic tray release and lever-operated cube release, a deep glass Meat Tender, two full length doors and a 10 position Cold-Control to adjust temperature to requirements. **Frigidaire Div., General Motors, Dept. MH, Dayton 1, Ohio. (Key No. 21)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Blood Bank Recording Alarm

A blood bank recording alarm which is completely portable so that it can be used to check all units where the hospital has more than one, is a system designed

to uncover faulty refrigerator performance before damage can be done to stored blood. It consists of a portable recording thermometer for use in the blood bank refrigerator and an alarm unit which stands on the floor outside the refrigerator, the refrigerator door closing over the flat connecting cord.

Placed on a shelf inside the refrigerator, the recording thermometer makes a chart record of temperatures inside the box. A buzzer alarm sounds if the temperature falls below 35.6 degrees F. or rises above 44 degrees F. A heavy duty battery actuates the buzzer, thus the alarm sounds in case of electric power failure to the refrigerator. **Taylor Instrument Companies, Dept. MH, 95 Ames St., Rochester 1, N. Y. (Key No. 22)**

Pipe Threader

The new Beaver 26-R is an improved version of the Beaver 26 pipe threader. The new model threads 1, $1\frac{1}{4}$, $1\frac{1}{2}$ and 2 inch pipe with one set of dies, ground to cut easily. Perfect alignment and straight pipe lines are assured by a self-centering chuck but "drip threads" may also be cut. The new threader is designed to cut either standard taper or straight electric conduit threads, also to cut standard, oversize or undersize threads of uniform length. **Beaver Pipe Tools, Inc., Dept. MH, Dana Ave., Warren, Ohio. (Key No. 23)**

Acoustical Plaster

Gold Bond Acoustical Plaster is a new product designed to provide "built-in" sound conditioning. Employing a new lightweight aggregate as the base of its formula, the new plaster is light and easy to handle and to apply. It is provided in 4 shades; natural, ivory, cream and buff. It is designed as a finish plaster requiring no decorating, although it may be spray-painted without appreciable loss of sound absorption.

The new plaster has a 70 per cent light reflection on the natural color material and its average noise reduction coefficient is .55. It can be adapted for use on flat surfaces, coves and barrel ceilings, around columns, in corners and on curves. **National Gypsum Co., Dept. MH, Buffalo 2, N.Y. (Key No. 24)**

Dry Chemical Extinguisher

Outstanding features of the new dry chemical type fire extinguisher include longer range; longer duration of discharge; more complete discharge of the dry chemical contents; gas-tight, all-internal expelling gas connections; built-in safety disc, and light weight. The dry chemical is nontoxic, non-corrosive and will not freeze. It is recommended for flammable liquid and electrical fires and is a hand portable unit, known as No. 30 Alfco Dry Chemical. **American-LaFrance-Foamite Corp., Dept. MH, Elmira, N. Y. (Key No. 25)**

Indirect Luminaire

The new Guth Seelux is an indirect luminaire of modern design for use with Silver Bowl Lamps. Louvers are of spun aluminum with a fine emery-grained finish permanently protected with the Alzak Aluminum process. The Silver Bowl Lamp used in the luminaire contains the major reflector and the fixture can be restored to initial efficiency merely by a lamp change. Open louvers facilitate maintenance. **The Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo. (Key No. 26)**

Bottle Washer

The Ogden Bottle Washer has been adapted for use in institutions and accommodates simultaneously all sizes of bottles up to one gallon, cleaning narrow or wide mouthed containers. It should be a time and labor-saver in cleaning nursing bottles and laboratory containers in the hospital. It is a compact self-contained unit requiring a minimum of floor space and it handles up to 8 bottles a minute.

Bottles are jet pressure cleaned by detergent solution with hot steam rinse. A wet steam bath or hot air drying may also be incorporated in the cleaning process after which the bottles, which are washed both inside and outside, are said to be sterile. **Ogden Filter Co., Dept. MH, 2414 Santa Monica Blvd., Los Angeles 27, Calif. (Key No. 27)**

Divide-A-Files

Self-Adjusting Divide-A-Files are a new feature of the Super-Filer cabinets recently announced by The General Fireproofing Company. The Divide-A-Files adjust automatically to changes in the volume of drawer contents, thus saving time and manual effort when filing or withdrawing material. They also break up the drawer load and keep the contents under compression when the drawer is closed.

With the swing front on the drawers of the new files, and the Self-Adjusting Divide-A-Files to create a rear slant, filing, finding and reference are facilitated and the entire drawer can be filled to capacity without having to save space for handling. **The General Fireproofing Co., Dept. MH, Youngstown 1, Ohio. (Key No. 28)**

Ice Cube Machine

Automatic operation of the new Ajax Electric Iceman provides 156 cubes of clear ice in approximately 30 minutes. The newly frozen cubes drop into an insulated storage compartment which holds up to 1400 cubes or 60 pounds of cube ice. The machine stops automatically when the storage space is filled and starts again automatically when sufficient ice has been removed.

The machine operates without recirculating water. Five quarts of fresh water are delivered to the machine at the start of the freezing cycle. When the four quarts are frozen, a defrosting action takes place and approximately one quart of water is siphoned off, after which the cubes drop into the storage compartment. The machine will provide up to 7500 cubes in a 24 hour period if needed. It is finished in white enamel with chrome trim and a clear plastic

hopper lid. The machine is manufactured by **Servel, Inc. of Evansville, Ind.**, and will be distributed exclusively by **The Ajax Corporation of America, Dept. MH, 176 W. Adams St., Chicago 3. (Key No. 29)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Equipment Identification

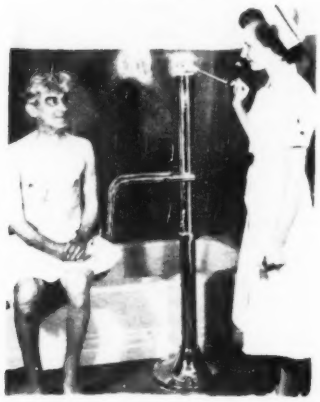
Quick and simple identification of hospital equipment is possible with the new Burgess Vibro-Graver, an electrical marking device which is used like a pencil and smoothly writes on steel, glass, plastic, wood and ceramic items. The device is supplied with a Diamond Point, Tantalum and Carbide Point for harder metals, glass, hardwood and plastics and with a Ball Point for soft wood and soft metals. It provides an ineradicable method of marking name, purchase dates, codes, inventory dates, floor numbers or series numbers on equipment.

The Vibro-Graver is available in a complete kit in a leatherette package. A booklet provided with the kit supplies instructions for operating this quick and inexpensive identification device. **Burgess Battery Co., Handicraft Div., Dept. MH, 180 N. Wabash Ave., Chicago 1. (Key No. 30)**

Interior Paint

Spred-Satin is the name given to a new interior paint recently announced. The new product has basic ingredients similar to those used in synthetic rubber, is easy brushing and has excellent flow qualities. It is practically odorless and is said to be dry enough to permit rehanging of pictures 20 minutes after application. The new paint is resistant to rubbing and can be spot-washed without losing color or sheen. It is fadeproof and provides a smooth finish which is impervious to dirt. Spred-Satin is available in 14 colors. **The Glidden Co., Dept. MH, 11001 Madison Ave., Cleveland 2, Ohio. (Key No. 31)**

Marti Inva-Lift



A device has recently been announced which makes it possible to move disabled or aged persons into and out of a bath tub. The patient sits on a hydraulically controlled seat which can be turned and lowered into the tub for bathing and then lifted out. Thus tub baths can be given in many cases where it would be difficult or impossible without the Inva-Lift.

Any disabled, crippled, aged or paralyzed patient who is able to sit up can be given a tub bath when this device is used. It is easily operated by the nurse or can be handled by the patient if necessary. It should prove of particular value in hospitals for chronic disease patients, Veterans' hospitals and similar institutions. **National Sales Co., Dept. MH., 612 Eddy Bldg., Saginaw, Mich. (Key No. 32)**

Water Cooler

Three models of the Oasis electric drinking water cooler have the new Oasis, hermetically sealed, static condensing unit which has been developed for quiet, trouble-free operation. The unit is air-cooled by natural air currents, resulting in lower operating costs and reduced service requirements. The new unit is available on the OP-5-S 5 gallon pressure bubbler model, the OB-R-S triple-purpose ice cube, bottle compartment model and the newly restyled bottle cooler, the OB-2-S. **Ebco Mfg. Co., Dept. MH, 401 W. Town St., Columbus 8, Ohio. (Key No. 33)**

Air Recovery Cell

A new, self-contained cell-type unit has been designed to be used in air conditioning and ventilating systems to recover or convert stale, odorous air to fresh air. Known as the Type "C" cell, the unit has a capacity of 1000 cubic feet of air per minute and has been designed to provide a simple, effective air purification device that can be installed and serviced easily. The new cell can be installed with no preliminary engineering design and minimum duct accommodations. For abnormal odor concentrations two cells in series per 1000 CFM are recommended by the manufacturer. **W. B. Connor Engineering Corp., Dept. MH, 114 E. 32nd St., New York 16. (Key No. 34)**

Heavy Duty Casters

A new line of forged steel precision casters for use on equipment carrying exceptionally heavy loads has been announced recently. Made of forged steel frame and top plate by improved construction, the new line uses high quality unit type of enclosed main load bearings and Timken thrust bearings. The casters are available in 5, 6, and 8 inch diameter wheel sizes. **The Bassick Co., Dept. MH, Bridgeport 5, Conn. (Key No. 35)**

Infant Incubator

The new Livsey Model 125 Infant Incubator employs radiant heating to maintain the desired temperature. The heating unit is sealed in the bottom and

back of the incubator, entirely outside the infant compartment. The incubator is ready to operate by connecting the cord to any 115 volt AC outlet. Temperature of the incubator is regulated by a dial on the front of the unit.

Regulated humidity is supplied by a water pan designed to furnish 65 per cent humidity and the thermometer panel is recessed into the metal panel of the incubator. Other features include dampers to regulate air flow; safety glass in lid and front; convenient storage cabinet with upper compartment sufficiently heated to warm clothing and blankets, and facilities for supplying oxygen when desired. **The Livsey Equipment Co., Dept. MH, 18938 Winslow Road, Cleveland 22, Ohio. (Key No. 36)**

Portable Posting Machine

A relatively inexpensive portable posting and figuring machine has been developed which should be of particular interest to smaller hospitals. Known as the Underwood Sundstrand Portable Posting Machine, it can be used for addition, subtraction, multiplication and division in addition to posting of accounts receivable, accounts payable, general ledger, payroll and other records. A complete record and proof of all work is automatically printed to permit accurate checking of all figures.

Operation of the machine is easily learned in a short time since all work is accomplished with a ten key natural sequence keyboard built for touch figuring. Being portable, the machine can be used on a desk, stand or table. It is built for all forms in standard business use. The machine has 14 automatic operations, resulting in less time and effort for the operator. **Underwood Corp., Dept. MH, 1 Park Av., New York 16. (Key No. 37)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Mimeograph Drawing Instruments

A new set of mimeograph drawing instruments manufactured of molded plastic has been announced by A. B. Dick Company. The new process of manufacture permits thicker lettering guides which do not slip or slide while in use; tapered character openings in the guides for easier insertion and accurate control of the stylus point; identification letters located below the character openings; dual lettering guides which give 2 alphabet styles on each dual guide; more uniform, smoother character openings and maintenance of dimensions, quality, uniformity and color fastness.

The new styli each have 2 working ends and are designed for production of ruled forms, for use with the lettering guides and for screen plate shading. The rectangular molded plastic handles with rounded finger grips prevent rolling on table or desk and a roll point stylus has been designed for writing signatures on stencils. Screen plates, which are used for shading, are also available in molded plastic in a 3 by 6 inch size which facilitates shading of large areas. The new line of drawing instruments was designed by Walter Dorwin Teague, industrial designer. **A. B. Dick Co., Dept. MH, 5700 W. Touhy Ave., Chicago 31, (Key No. 38)**

Electric Wheel Chair

The new Autoette Electric Wheel Chair has simple, one-hand operation and is powered by a specially designed, light weight battery with power for about 5 miles daily use and a charger for recharging the battery by plugging into any AC outlet. The new chair is available in two models, the Standard and the Deluxe. The latter is equipped with adjustable foot rests and pneumatic tires.

The chair starts and stops smoothly, has two-speed control, and is designed to eliminate the necessity for a constant companion with patients confined to a chair. It is large enough for comfort but small enough to assure easy passage through average doors and halls. The Autoette moves either forward or in reverse. **Everest & Jennings, Dept. MH, 761 N. Highland Ave., Los Angeles 38, Calif. (Key No. 39)**

Stainless Steel Extinguishers

Buffalo fire extinguishers are now available in all welded stainless steel. The new material makes the extinguisher stronger even though it is lighter in weight and hence easier to handle. The permanent finish simplifies maintenance and the new model is available in both Soda-Acid and Foam types. **Buffalo Fire Appliance Corp., Dept. MH, Dayton 1, Ohio. (Key No. 40)**

Pharmaceuticals

Neo-Synephrine with Penicillin

The new stable combination package of Neo-Synephrine with Penicillin in "Niphanoid" form contains one vial of a mixture of 25 mg. Neo-Synephrine and 50,000 units of crystalline penicillin G sodium, with a second vial containing 10 cc. of special buffered isotonic saline solution to be used as a diluent. The resulting solution is indicated for the treatment of congestion and infections of the nasal passages. The combination package will remain stable for one year at room temperature. Refrigeration is not required until the two vials are put in solution. **Winthrop-Stearns Inc., Dept. MH, 170 Varick St., New York 13. (Key No. 41)**

Penni-Morph

Penni-Morph is a mixture of morphine sulfate and a special suspending medium which prolongs the pain relieving effects of the morphine, making repeated injections unnecessary. Indicated as a sedative and analgesic following surgery, the product is also suggested to relieve the pain caused by cancer and other inoperable conditions. The new drug is being used in a series of clinical investigations. **Injectables Research Corp., Dept. MH, Indianapolis, Ind. (Key No. 42)**

Coricidin

Coricidin tablets have been developed for aborting and treatment of the common cold. Combining antihistaminic analgesic-antipyretic ingredients, Coricidin tablets are indicated at the onset of the first symptoms of a common cold. The principle ingredient is Chlor-Trimeton, Schering's new antihistaminic drug. The tablets are supplied in vials of 12 and bottles of 100 and 1000. **Schering Corp., Dept. MH, Bloomfield, N. J. (Key No. 43)**

Caubren Compound

Caubren Compound, designed to combat the common cold, is a balanced combination of three active drugs, Chlorothen Citrate, acetophenetidin and caffeine. Chlorothen is an antihistaminic of low toxicity which, combined with the analgesic and antipyretic qualities of the other compounds produces an effective cold combatant for early administration at the first symptom of a common cold. The product is supplied in bottles of 100 tablets. **Whittier Laboratories, Div. Nutrition Research Laboratories, Dept. MH, 4210 Peterson Ave., Chicago 30. (Key No. 44)**

Aureomycin Hydrochloride

Aureomycin Hydrochloride Lederle, with a wide range of activity against many types of infection, and heretofore available only in capsule form, is now being offered in other preparations. Aureomycin Hydrochloride Ointment for the treatment of many infections of the skin, contains 3 per cent by weight of aureomycin and is designed for topical application only. Aureomycin Hydrochloride Troches, for action upon the mucous membranes of the mouth, oropharynx and upper respiratory tract, furnish a means of dissolving small quantities of aureomycin in the saliva and continuously bathing the tissues of the area with the drug.

This antibiotic, Aureomycin, is potent against a wide range of gram-negative and gram-positive organisms and is specific against rickettsial infections. It is also useful against bacteria which have become resistant to penicillin, streptomycin or sulfonamides and with patients who exhibit severe sensitivity to these drugs. The capsules, 50 mg. each, are supplied in bottles of 25, 250 mg. each in bottles of 16; the ointment is supplied in tubes of 1 ounce, the ophthalmic ointment in vials of 25 mg. with dropper; solutions prepared by adding 5 cc. of distilled water, and the troches in bottles of 25, 15 mg. each. **Lederle Laboratories, Dept. MH, 30 Rockefeller Plaza, New York 20. (Key No. 45)**

Terfonyl

Terfonyl is the name given the new Squibb triple sulfonamide containing sulfadiazine, sulfamerazine and sulfamethazine. It produces higher blood levels with fewer toxic reactions than would be possible with a single sulfonamide in the same total amount. Terfonyl is indicated in infections susceptible to treatment by any sulfonamide. It is supplied in 0.5 Gm. tablets in bottles of 100 and 1000 and in suspension in 0.5 Gm. per cc. in pint bottles. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 46)**

Hydro-Bilein Tablets

A mixture of dehydrocholic acid and dried fresh ox bile which has been treated to remove pigments, cholesterol and fats, each Hydro-Bilein Tablet contains Bilein 2 grs. and dehydrocholic acid 2 grs. The tablets are indicated for replacement therapy to improve digestion and absorption of food, particularly fat and the fat soluble vitamins, when bile salts are absent from the intestinal tract. They are supplied in bottles of 100 and 1000. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 47)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Product Literature

• The complete line of J-M Asphalt Tile colors, including colors added this year, is shown in the center spread of a folder recently issued by Johns-Manville, 22 E. 40th St., New York 16. Various patterns possible with J-M Asphalt Tile for reception rooms, classrooms, corridors and offices are shown in full color in this **"Johns-Manville Asphalt Tile"** leaflet. **(Key No. 48)**

• "Kitchen-tested" features and design and construction features of **"Despatch Electric Baking and Roasting Ovens"** are discussed in a booklet recently issued by Despatch Oven Co., 619 S. E. 8th St., Minneapolis 14, Minn. General information on baking is presented together with comprehensive data on the company's electric ovens described as "the modern recipe for better cooking." **(Key No. 49)**

• The new **Catalog No. 212, "Hamilton Laboratory Equipment for Research and Control,"** issued by Hamilton Mfg. Co., Two Rivers, Wis., is a most attractive, plastic bound book giving information on the Hamilton Unit Plan and why it was developed with full descriptions and illustrations of the complete Hamilton line of laboratory equipment. The catalog is supplemented by a booklet of "Specifications, Laboratory, Pharmacy and Dental Equipment," **Booklet No. AL-50,** covering materials, construction, finishes and test. **(Key No. 50)**

• Forms, properties and methods of installing Fiberglas acoustical materials, including plain and perforated tile and board, are discussed in an 8 page booklet issued by Owens-Corning Fiberglas Corporation, Toledo 1, Ohio, **"Acoustical Materials for Quiet and Beauty—With Fire Safety."** Use of Fiberglas thermal insulations for acoustical purposes is discussed and the booklet is illustrated with application photographs and diagrammatic drawings. **(Key No. 51)**

• Full information on Ampins, the sterile, disposable unit ready for instant administration of injectable solutions, is given in a folder on the **"Automatic Injection With Ampins of Crystalline Procaine Penicillin G"** issued by Strong Cobb & Co., Inc., 2654 Lisbon Rd., Cleveland 4, Ohio. A diagrammed drawing of the Ampin, together with directions for its use in intramuscular injection, make the leaflet of additional interest. **(Key No. 52)**

• Detailed information on **Amigen,** the protein hydrolysate for parenteral use, is given in a booklet issued by Mead Johnson & Co., Evansville, Ind. Bound in plastic so that it opens flat, the 30 page booklet has quick-reference subject headings. **(Key No. 53)**

• The complete line of **"Blickman-Built Nursery and Pediatric Equipment"** is illustrated and described in a 24 page catalog recently published by S. Blickman, Inc., Weehawken, N. J. Equipment covered includes the line of bassinets, dressing and examining tables, general nursery equipment and milk formula room equipment. **(Key No. 54)**

• The **"Kewaunee Book of Hospital Casework"** contains a wealth of helpful data on the full line of equipment manufactured by Kewaunee Mfg. Co., Adrian, Mich. The attractively produced 88 page book gives general information on the line and the company policies, complete construction specifications, diagrammatic illustrations of construction details, and detailed descriptions of each item. In addition to full information on the cabinets, shelving, solution warming cabinets, chart tables, storage cabinets, service fixtures and other items, there are pages showing standard hospital assemblies with typical floor plans and elevation drawings for installations in laboratory, morgue, pharmacy, nursery, operating rooms, nurses' stations, utility rooms and other areas in hospitals of various sizes. **(Key No. 55)**

• **"The Sound Way to Maintain Medical and Hospital Records"** is the title of a folder recently issued by Gray Audograph Corp., 620 N. Michigan Ave., Chicago 11. Detailed information on the Gray Audograph Electric Soundwriter and its many uses in the hospital for dictating medical records, correspondence, notes and other material and for making records of meetings and interviews is given in the folder together with operating instructions. **(Key No. 56)**

• Two new leaflets have been issued by the Maple Flooring Manufacturers Assn., 46 Washington Blvd., Oshkosh 7, Wis., to indicate the possibility of lower maple flooring costs without loss of floor quality. Entitled **"Where 'Second Grade' Means 'Excellent'"** and **"Use Third Grade for Economy,"** the leaflets are designed to tell hospital architects and administrators how quality in flooring can be maintained with savings in costs and the economy and quality of third grade northern hard maple flooring for limited budgets. **(Key No. 57)**

• A new series of **quantity recipes** has been developed by the Quaker Institutional Kitchen and is printed on 4 by 6 inch cards, each with a hole at the top so that it can be hung up during use. The first set in the new series consists of 11 recipes of 50 servings each covering breads, cookies, pancakes and waffles, meat loaf and other foods. The recipe cards are available from The Quaker Oats Company, 141 W. Jackson Blvd., Chicago 4. **(Key No. 58)**

• **"Plan Your Hospital's Atmosphere"** is the title of an attractively produced booklet issued by Minneapolis-Honeywell Regulator Co., 2665 Fourth Ave. S., Minneapolis 8, Minn. Included in the booklet are data on temperature in the various departments of the hospital and how it can be individually maintained at the levels required for best results and greatest comfort. The booklet is fully illustrated and describes how "controlled atmosphere" can be maintained. **(Key No. 59)**

• **"Safety of the Trust Fund is the first care of the law and the first duty of the Trustees"** is the statement made on the cover of a new booklet issued by the Insurance Company of North America Companies, 1600 Arch St., Philadelphia 1, Pa. The booklet is designed to make clear the responsibility of trustees for preserving trust funds and making sure that adequate insurance is provided. The booklet points out that recent catastrophes have caused trustees and administrative officials of colleges, universities, hospitals and similar organizations to review their responsibilities and cites court decisions. **(Key No. 60)**

Book Announcements

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Abernethy, "Principles of Organic Chemistry," 317 pp., $4. Allee, Emerson, Park and Schmidt, "Principles of Animal Ecology," 837 pp., $14. Brethorst, "Methods of Teaching in Schools of Nursing," 362 pp., $4. Brown, "Clinical Instruction," 571 pp., $5.50. Jordan-Burrows Textbook of Bacteriology, 15th Ed., 981 pp., $9. Cantarow and Trumper, "Clinical Biochemistry," 4th Ed., 642 pp., $8. Frobisher, "Fundamentals of Bacteriology," 4th Ed., 936 pp., $5.50. Howell, "A Textbook of Physiology," 16th Ed., 1258 pp., $10. Lyon and Wallinger, "Mitchell's Pediatrics and Pediatric Nursing," 3rd Ed., 590 pp., $3.75. Preher and Calvey, "Sociology with Social Problems Applied to Nursing," 505 pp., $4. Romer, "The Vertebrate Body," 643 pp., $5.50. Thompson, "Introduction to Microorganisms," 2nd Ed., 454 pp., $4.25. **(Key No. 61)**

The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md. Zacks, "Photoradiography in Search of Tuberculosis," 302 pp., $5. **(Key No. 62)**

Suppliers' News

The Aluminum Cooking Utensil Co., New Kensington, Pa., manufacturer of aluminum cooking and clinical utensils, announces the appointment of **B. E. Hiles** as Manager of the Hotel and Industrial Division, succeeding **George**

Address manufacturers for further information and prices—or use Readers' Service blank on page 244

Peters who retired August 31 after 39 years association with the company.

Angelica Jacket Co., 1419 Olive St., St. Louis 3, Mo., manufacturer of uniforms, announces the appointment of **Stanley A. Weiser** as **Hospital Division Manager.** He will supervise the designing and production of a complete new line of Angelica hospital garments.

The G. S. Blodgett Co., Inc., Burlington, Vt., manufacturer of baking and cooking equipment, announces the appointment of **Paul C. Grimes** as **Sales Manager.**

Cutter Laboratories, Berkeley 1, Calif., manufacturer of pharmaceutical products, announces the election of **Donn R. Court** as **Vice-President in charge of Sales.**

Davis & Geck, Inc., 57 Willoughby St., Brooklyn 1, N. Y., manufacturer of surgical sutures, announces the election of **Charles P. Collins** as **Vice-President** and his appointment as **General Manager** of the corporation.

Doughnut Corporation of America, 393 Seventh Ave., New York 1, manufacturer of bakers' supplies, announces opening of a new **scientific research laboratory** at **42 Stone St., New York.**

Ethicon Suture Laboratories, Incorporated, New Brunswick, N. J., manufacturer of surgical sutures, is now a separate corporation and no longer a division of Johnson & Johnson. The separation is made in accordance with Johnson & Johnson's policy of decentralization. **Philip B. Hofmann** has been appointed **President** of the new corporation.

Hild Floor Machine Co., manufacturer of floor maintenance equipment, announces completion of its new building at **740 W. Washington Blvd., Chicago 6.** Complete office, demonstration and factory facilities are included in the new modern building.

The Wm. S. Merrell Co., Cincinnati 15, Ohio, manufacturer of pharmaceutical products, announces the election of **Nelson M. Gampfer** as **President and General Manager.**

V. Mueller & Co., manufacturer and supplier of surgical instruments and equipment, announces removal of its general offices, manufacturing facilities and warehouse to a new main plant at **320 S. Honore St., Chicago 12.** The new modern quarters permit expansion of office and service facilities and combine all the firm's manufacturing divisions, with the exception of the Indianapolis plant.

O.E.M. Corporation is the new corporate name of the Oxygen Equipment Mfg. Corp., manufacturers of a complete line of medical oxygen equipment. The company has moved from New York City to a new, modern plant designed to their specialized manufacturing needs on **Fitch St.,** in **East Norwalk, Conn.**

The Fresco Co., manufacturer of odor filters for refrigerators and coolers, announces removal of its offices and factory from 6225 Brookside Blvd., Kansas City 2, Mo. to **526 N. Main St., Hendersonville, N. C.**

Standard Gas Equipment Corp. of Baltimore, Md. and **Hart Mfg. Co. of Louisville, Ky.** announce the consolidation of their commercial cooking equipment lines. The entire resources of the new organization will be devoted exclusively to commercial cooking equipment. Vulcan equipment will continue to be manufactured in Baltimore and Hart restaurant and luncheonette equipment will be manufactured in Louisville.

Changes of Address were incorrectly given for the following firms in earlier issues. The correct addresses follow:

National Association of Ice Industries, 1706 L St. N. W., Washington 6, D. C.

Standard Scientific Supply Corp., 34 W. Fourth St., New York 12.

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

☐ 1	Undercounter Refrigerator	☐ 32	Marti Inva-Lift
☐ 2	Non-Allergenic Gloves	☐ 33	Water Cooler
☐ 3	Plastic Asphalt Tile	☐ 34	Air Recovery Cell
☐ 4	Static Detector	☐ 35	Heavy Duty Casters
☐ 5	Two Crank Spring	☐ 36	Infant Incubator
☐ 6	Portable Oxygen Carriers	☐ 37	Portable Posting Machine
☐ 7	Noiseless Typewriter	☐ 38	Mimeograph Drawing Instruments
☐ 8	Plastic Base Coving	☐ 39	Electric Wheel Chair
☐ 9	Standardized Boilers	☐ 40	Stainless Steel Extinguisher
☐ 10	Antiseptic Detergent	☐ 41	Neo-Synephrine With Penicillin
☐ 11	Sunlighter Fixture	☐ 42	Penni-Morph
☐ 12	Double-Action Floor Wax	☐ 43	Coricidin
☐ 13	No-Gear Peeler	☐ 44	Caubren Compound
☐ 14	Combination Dishwasher-Boiler	☐ 45	Aureomycin Hydrochloride
☐ 15	Magic-Swivelock Casters	☐ 46	Terfonyl
☐ 16	Floor Machine	☐ 47	Hydro-Bilein Tablets
☐ 17	Labseal	☐ 48	"Asphalt Tile"
☐ 18	Conference Top Desk	☐ 49	"Despatch Ovens"
☐ 19	Guardian Safe	☐ 50	Catalog No. 212
☐ 20	Hydraulic Bedlifter	☐ 51	"Acoustical Materials"
☐ 21	Refrigeration Equipment	☐ 52	Ampins
☐ 22	Blood Bank Recording Alarm	☐ 53	Amigen
☐ 23	Pipe Threader	☐ 54	Catalog
☐ 24	Acoustical Plaster	☐ 55	"Hospital Casements"
☐ 25	Dry Chemical Extinguisher	☐ 56	"Hospital Records"
☐ 26	Indirect Luminaire	☐ 57	Maple Flooring Leaflets
☐ 27	Bottle Washer	☐ 58	Quantity Recipe Cards
☐ 28	Divide-A-Files	☐ 59	"Hospital's Atmosphere"
☐ 29	Ice Cube Machine	☐ 60	Trustees Booklet
☐ 30	Equipment Identification	☐ 61	Books
☐ 31	Interior Paint	☐ 62	Book

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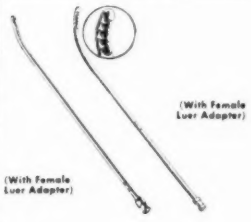
SKLAR

These instruments, precision-built by Sklar highly skilled craftsmen of finest quality, American-made stainless steel, greatly facilitate and simplify the removal of uterine specimen tissue for diagnostic procedures. As with all Sklar instruments, their excellence of design, high functional efficiency and safety, durability and dependability, mark them as instruments of outstanding value in implementing appropriate techniques of the physician and surgeon.

Designed by S. R. Gusberg, M.D., College of Physicians and Surgeons, Columbia University, New York City.

Gusberg Endocervical Curette

Painlessly secures a cone of tissue from the squamous-columnar junction of the cervix. May be used for tissue confirmation with vaginal smear screening technique, or as primary scouting method. Three sizes: Small, Medium, Large—Stainless Steel. Sklar Catalog No. S-5815



Randall Endometrial Biopsy Curette

For use in obtaining endometrial specimens without anesthesia or dilation of the os. Sklar Catalog No. S-5804

Novak Endometrial Biopsy Curette

For use in endometrial suction-curettage technique. Permits thorough uterine curettage, without anesthesia. Stainless Steel. Sklar Catalog No. S-5805

Designed by T. B. Hannon, M.D., Baylor Medical College, Houston, Texas

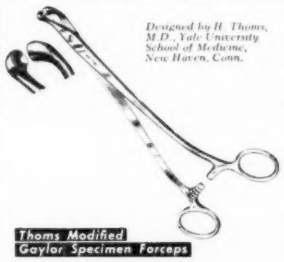
Hannon Endometrial Biopsy Curette

For securing endometrial and cervical scrapings for microscopic study. Stainless Steel. Sklar Catalog No. S-5810

Designed by H. Thoms, M.D., Yale University School of Medicine, New Haven, Conn.

Thoms Uterine Tissue Grasping Forceps

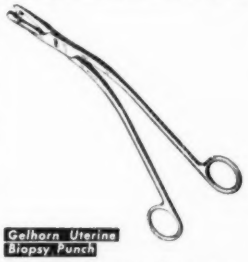
New instrument to be used either as tenaculum, or for grasping tissue to be removed by knife, scissors or biopsy instrument. Jaws have 6 x 7 teeth. Stainless Steel. Sklar Catalog No. S-6502½



Designed by H. Thoms, M.D., Yale University School of Medicine, New Haven, Conn.

Thoms Modified Gaylor Specimen Forceps

Telescoping edges of grasping cups give shear action to cutting edges, facilitating procurement of cervical specimen for biopsy. Stainless Steel. Sklar Catalog No. S-6561



Gelhorn Uterine Biopsy Punch

Spiked grasping cup, with positive shearing action of telescoping cutting edges, assures easy removal of uterine specimen for diagnostic examination. Stainless Steel. Sklar Catalog No. S-6567½

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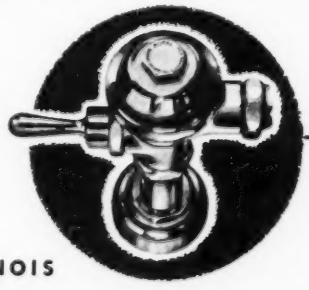

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